DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: July 26, 2023

ALL PLAN LETTER 23-020

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: REQUIREMENTS FOR TIMELY PAYMENT OF CLAIMS

PURPOSE:
The purpose of this All Plan Letter (APL) is to remind Medi-Cal managed care plans (MCPs) of their legal and contractual obligation to timely pay claims submitted by Providers for Covered Services to MCP Members.

BACKGROUND:
MCPs must ensure they, their Subcontractors, and their Downstream Subcontractors, operate in full compliance of the Contract,[1] applicable state and federal statutes and regulations, APLs, and all other applicable policy guidance relative to timely payments to Providers. MCPs are responsible for communicating timely claims payment requirements to all Subcontractors and Downstream Subcontractors.

POLICY:

1. **Timely Payment of Claims**

MCPs must pay all claims within contractually mandated statutory timeframes[2] and in accordance with the timely payment standards in the Contract[3] for clean claims.[4] This includes equivalent encounter submission, or bills or invoices submitted by Providers that adhere to billing and invoicing guidance such as for Enhanced Care Management (ECM), Community Supports services, and for Intermediate Care Facilities for the Developmentally Disabled.

MCPs must maintain sufficient claims processing/tracking/payment system capabilities to comply with the contractual and statutory standards set forth below.

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[1] MCP boilerplate Contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are also advised to review their specific MCP Contracts and amendments executed thereto.
[2] MCP Contract, Exhibit A, Attachment 8, Provision 5, Claims Processing; Health and Safety Code (HSC) sections 1371(a) and 1371.35 (a); Title 28, California Code of Regulations (CCR) section 1300.71(g). The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[3] MCP Contract, Exhibit A, Attachment 8, Provision 5, Claims Processing.
[4] A "clean claim" is defined in 42 Code of Federal Regulations (CFR) section 447.45(b). CFR is searchable at https://www.ecfr.gov/current/title-42.

The Department of Health Care Services (DHCS) encourages MCPs to go beyond the minimum requirements, to the extent feasible, regarding the timely payment of claims in an effort to support and sustain Providers to ensure access to care. Some Providers do not have the same financial reserves or diverse payer mix as others and rely on prompt payment from the Medi-Cal program through their MCPs to sustain services to Members.

If an MCP has delegated the adjudication of claims for emergency service and care to a capitated Subcontractor, the MCP must forward at least 95 percent of such claims that were misdirected to the MCP to the appropriate capitated Subcontractor within ten Working Days of receipt of the claim of when it was sent to the MCP erroneously. If the MCP has delegated the adjudication of claims for services that do not involve emergency services and care to a capitated Subcontractor, the MCP must either forward at least 95 percent of such claims that were misdirected to the MCP to the appropriate capitated Subcontractor or send a notice of denial, with instructions to bill the appropriate capitated Subcontractor within ten Working Days of receipt of the claim of when it was sent to the MCP erroneously.[5,6]

a. DHCS Expects MCPs to Pay Clean Claims within 30 Days of Receipt

The Contract requires that MCPs comply with HSC sections 1371 through 1371.36, which govern Provider compensation.[7] In addition, the Contract requires adherence to federal Medicaid requirements which dictate 90 percent of all clean claims from practitioners, who are in individual or group practices or who practice in shared health facilities, be paid within 30 days of the date of receipt, and 99 percent of all clean claims be paid within 90 days of receipt.[8]

DHCS expects MCPs to pay clean claims within 30 calendar days of receipt.

If the MCP contests a portion of a claim, it must reimburse any uncontested portions of the claim within the statutory timeframes.[9] If the MCP contests or denies all or a portion of a claim, it must specify the reason(s) for the contest or denial within the statutory timeframes.[10] MCPs are prohibited from requesting irrelevant or unnecessary information from Providers during claims processing. If the MCP needs additional

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[5] Title 28 CCR section 1300.71(b)(2). Title 28 CCR section 1300.71 refers to these capitated Subcontractors as “capitated providers.” To avoid confusion, this APL uses the contractual term “capitated Subcontractors.” For the purposes of this APL, the term “capitated Subcontractor” has the same meaning as “capitated provider,” as defined in Title 28 CCR section 1300.71(a)(1)(B).
[6] Title 28 CCR section 1300.71(a)(8)(B)
[7] MCP Contract, Exhibit A, Attachment 8, Provision 5, Claims Processing.
[8] Id.; 42 CFR section 447.45.
[9] HSC sections 1371(a)(1);1371.35(a); Title 28 CCR section 1300.71(g), (h).
[10] HSC sections 1371(a)(1) and 1371.35(a); Title 28 CCR section 1300.71(d)(1), (h).

information to complete the claim, it must specify the reason additional information is necessary to complete the claim[11] and must do so within the statutory timelines.[12]

b. MCPs Must Pay Interest on Untimely Payments

If an MCP does not pay a clean claim within 30 Working Days of receipt, it will owe the Provider interest at the rate of 15 percent per annum beginning on the first day after a 30 Working Day period.[13] For the purposes of calculating interest, the first day is considered to be the first calendar day after 30 Working Days following the receipt of the claim. The MCP must automatically include all accrued interest in any late payment.[14]

2. Payments Related to State Directed Payments

MCPs must, as applicable adhere to timely payment requirements regardless of whether a Provider's claim, bill, invoice, or equivalent encounter is tied to a State Directed Payment (SDP). MCPs are not subject to timely payment of SDPs until so directed and the 30 calendar-day standard outlined above does not apply in instances where the SDP amount is not published prior to the service date.

3. Provider Training Responsibilities

MCPs must ensure that Provider Manuals issued to Network Providers, Subcontractors, and Downstream Subcontractors have up-to-date policies and procedures (P&Ps) on how to submit clean claims to MCPs. This includes billing and invoicing processes for ECM Providers; Community Support Providers; doulas, or other community based Providers that are unable to submit claims through an electronic file format.

MCPs must ensure that all P&Ps regarding claims processing, billing and invoicing are up-to-date and reflective of current practices. For rejected claims and invoices, MCPs must include sufficient detail on the additional information and/or appropriate billing codes the Provider needs to submit a clean claim for the MCP's review. Claims and billing materials must be publicly accessible for all Providers.

In addition to issuing clear P&Ps, MCPs must ensure that all Providers are afforded education and training on their billing, invoicing, and clean claims submission protocols. This includes education and training about the Providers' obligation to refrain from billing Members for Covered Services, even if the MCP pays late or denies payment for a claim. For Providers who are not billed on a fee-for-service basis, MCPs are required

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[11] HSC section 1371(a)(3); Title 28 CCR section 1300.71(d)(2).
[12] HSC sections 1371(a)(4) and 1371.35(e).
[13] See definition of "Working Days" at MCP Contract, Exhibit E, Attachment 1.
[14] HSC section 1371 (a)(2).

to ensure that Providers are educated on appropriate processes for submission of Encounter Data.

Training must start within ten Working Days and be completed within 30 Working Days after MCPs place a newly contracted Network Provider on active status.

MCPs must routinely evaluate effectiveness of the training and make adjustments as needed. DHCS encourages MCPs to hold office hours or other open door approaches to working with their Providers, particularly if systemic billing concerns are identified.

DHCS recognizes MCPs have established Provider portal and electronic mechanisms to facilitate claims and equivalent encounter transactions. DHCS encourages MCPs to use standardized mechanisms to facilitate Provider claims and equivalent encounter transactions. At a minimum, MCPs are required to ensure Providers have the training to effectively use electronic systems to facilitate timely submission of clean claims, equivalent encounters, or bills or invoices.

4. Dispute Resolution

In accordance with HSC section 1367(h), MCPs must have a fast, fair, and cost-effective dispute resolution process in place for Providers, Network Providers, Subcontractors, and Downstream Subcontractors to submit disputes for both contracted and non-contracted Providers. This includes disputes related to Provider claims and payments.

MCPs must have a formal procedure to accept, acknowledge, and resolve Provider, Network Provider, Subcontractor, and Downstream Subcontractor disputes. The resolution process must occur in accordance with the timeframes set forth in HSC sections 1371 and 1371.35 for both contracted and non-contracted Providers.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD Contract Manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are further responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract

requirements, and other DHCS guidance, including APLs and Policy Letters.[15] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance.[16] Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[15] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, and any subsequent updates.
[16] For additional information regarding administrative and monetary sanctions, see APL 23-012, Enforcement Actions: Administrative and Monetary Sanctions, and any subsequent updates.