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Medi-Cal Managed Care Explainer
Key Terms for Navigating Medi-Cal Processes

Organizations exploring how to provide Medi-Cal benefits and services for the first time, including Enhanced Care Management (ECM) and Community Health Worker (CHW) services, must contract with managed care plans (MCP) to participate in and be reimbursed by Medi-Cal.

This explainer is for organizations seeking to understand basic Medi-Cal managed care terms before diving deeper on provider requirements for specific Medi-Cal services.

Contracting with Medi-Cal MCPs

In any particular county, people enrolling in Medi-Cal could have the option to enroll with one MCP or up to six MCPs. Therefore, organizations seeking to provide Medi-Cal services must consider how many MCPs they would like to contract with and which ones. The California Department of Health Care Services (DHCS) requires plans in shared counties to standardize as much as possible, but organizations can still expect to find a certain degree of variability in operations from plan to plan. In general, there are barriers to a truly streamlined experience for organizations seeking to provide Medi-Cal services in counties with several MCPs.

California Managed Care Regulation: What it Means for Providers

Medi-Cal MCPs are regulated by several statutes and agencies at the federal and state levels. To maintain accreditation, MCPs must meet certain quality standards established by the National Committee for Quality Assurance (NCQA). MCPs can be subject to a variety of penalties for failing to meet regulatory requirements. These consequences are designed to ensure that MCPs meet the high standards required and ensure Medi-Cal members receive the services to which they are entitled. The regulatory and standards pressures play important roles in determining the processes MCPs put in place for establishing and overseeing provider networks. Consider demonstrating how your services can help MCPs meet these standards.

Key Managed Care Terms that Organizations Must Know

- ✔ Provider Application and Validation for Enrollment (PAVE) Portal:
  - This electronic system is used by DHCS to track organizations and individual providers who are applying to become Medi-Cal providers. DHCS requires all California Advancing and Innovating Medi-Cal (CalAIM) providers to enroll as Medi-Cal providers. Most MCPs require copies of the PAVE registration, or evidence of application and rejection, as part of the larger credentialing process. Visit the DHCS PAVE webpage for more information on how to register providers in the PAVE system.
- ✔ National Provider Identifier (NPI):
  - An NPI is a unique number assigned to health care organizations and health care practitioners by the federal Centers for Medicare and Medicaid Services (CMS) — the agency that oversees Medicaid. NPIs exist both for individual health care practitioners and at the organizational or site level. NPIs are required to participate in Medi-Cal. The NPI connects the provider to reimbursable services billed on a health care claim. The NPI number must be used when submitting claims for health care services to obtain reimbursement. Visit this NPI application guide to learn more about obtaining NPIs.
- ✔ Clearinghouse:
  - If a provider is submitting electronic claims for reimbursement, MCPs may request that they come through a "clearinghouse." The clearinghouse acts as a middleman, checking the claims for errors before sending them to the MCP. This helps speed up the process and reduces the chances of claims being rejected. By using a clearinghouse, health care providers can ensure claims are submitted correctly and get paid more quickly for the services rendered.
- ✔ Healthcare Common Procedure Coding System (HCPCS):
  - This is a standardized code set used in health care to identify medical services, procedures, equipment, and supplies. This communicates to MCPs and DHCS the services that were provided for purposes of reimbursement, medical history, and other purposes, including future rate setting. These codes ensure that services can be identified consistently across the health care system. DHCS has identified specific HCPCs codes that are required for most CalAIM services. Providers are required to use these codes to be reimbursed.

- Remittance Advice (RA):
  - This is a detailed report sent by MCPs to providers explaining how claims were processed and how much the provider will be paid for the services rendered. The RA shows if adjustments were made, such as denied claims, and the reasons for rejections. This helps providers understand the status of their claims, allowing them to determine next steps, such as correcting claims or submitting provider dispute resolution requests for appealing denials.
- Provider Dispute Resolution (PDR):
  - When a provider believes that one or more claims denials are inappropriate, they can submit a PDR request to get the claim reviewed again by the MCP. If a provider is experiencing a significant volume of PDR requests resolved in their favor, it may indicate other systems challenges originating at the MCP.
- Grievances and Appeals:
  - A *grievance* is a formal complaint filed by a patient or provider when they are dissatisfied with the services or treatment provided by the MCP. This can include issues like long wait times, poor provider behavior, or access to care challenges. An appeal is a request made when a patient or provider disagrees with a decision made by the MCP, such as denying coverage for a service or refusing to pay a claim. MCPs are required to investigate and respond to both, typically within strict timeframes. For this reason, MCPs will require swift responses from providers on cases to meet DHCS requirements.