

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Payer Training Presentation





Payers Training Overview and Learning Objectives

- This training course is intended to serve as an overview of the content in the Payers Volume of the Surge Standards and Guidelines Manual. It is designed to be used as tool for organizations developing training programs on their surge plans. Organizations should use this training course as a starting point and customize it to include organization specific surge planning objectives.
- This training course, and the Payers Volume of the Standards and Guidelines Manual, is intended to assist representatives from commercial health plans, network providers, public payers and employer groups to work together to address the impact that a healthcare surge might have on the healthcare system, including health plan and provider operations, contractual requirements, premium payments and member coverage.
- With this goal in mind, this document contains general and specific planning considerations that health plans can use in managing their various products and relationships during a healthcare surge.

Upon completion of this course, you should:

- Be able to list general health plan and provider planning considerations, including charge capture and billing recommendations, which should be discussed in advance through contract provisions.
- Be able to differentiate between product-specific planning considerations and suggested guidelines for managing commercial, Medicare Advantage and Medi-Cal Managed Care business.
- Be able to describe the California authority governing health plans during a healthcare surge.



Overview of Payers Volume

Payers Volume, Section 1.4

- Health plans play a key but distinct role during a catastrophic emergency and have unique issues that must be addressed, including:
 - The network model in a surge environment may be disrupted.
 - Pre-authorization requirements could limit provider payment for some services.
 - Administrative complications and deficiencies may present themselves during a healthcare surge.
 - The increased volume of claims may put a strain on health plan reserves, systems and processes.
 - Employer premium payments and eligibility listings during a healthcare surge may be late, missing and/or inaccurate.
 - The circumstances surrounding a healthcare surge may create business continuity challenges when information technology is unavailable.
 - Members may be seen at Alternate Care Sites during a healthcare surge and although health plans are not financially liable for these service, surge planning should include a process to collect health related data from Alternate Care Sites.
- Addressing these issues can promote patient care, access and funding, business continuity and sustained operations at facilities providing medical care during a healthcare surge.



Healthcare Surge Response and Disaster Recovery Payers Volume, Section 2.1

- As current policies and regulations governing emergency provisions do not fully address all of the potential funding and reimbursement issues that may arise during a healthcare surge, health plans may want to consider developing disaster recovery plans to address how their organization will respond during a healthcare surge.



- As guidance for disaster recovery plans, the U.S. Office of Personnel Management has begun requiring in their Federal Employee Health Benefits Plan contracts that carriers have “a disaster recovery plan that addresses flexibility” for certain services.
- The U.S. Office of Personnel Management disaster recovery plan requirements can serve as guidance for health plans to develop a disaster recovery plan that suits their organization’s operational needs.



Planning Considerations Across Multiple Product Types Payers Volume, Section 2.2

- Maintaining existing revenue streams during healthcare surge will likely depend on health plan and provider organizations addressing disaster-related concerns in advance through contract provisions. Sufficient planning and coordination between health plans and providers will be essential to maintaining business continuity and sustaining operations at facilities providing medical care during a healthcare surge.
- Health plans often offer multiple products, including commercial, Medicare Advantage, Medi-Cal Managed Care and Workers' Compensation. Many of the recommendations for managing and preparing for a healthcare surge response are applicable to multiple products. These recommendations apply to rates, policies and procedures, and access and coverage. Examples of these recommendations are presented below:
 - Simplify rate structure for hospitals which may include negotiating a global acute care for inpatient care.
 - Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses.
 - For closed network models, revise preauthorization and referral requirements to allow access to care when needed and where available.



Health Plans and Commercial Products

Payers Volume, Section 2.3

- The majority of health plans in California provide healthcare coverage to individuals and families through either an employer sponsored plan or individual purchase.
- While health maintenance organization benefit plans continue to be the dominant model in California, health plans are offering a greater selection of plans with consumer driven features. These trends cause additional administrative challenges for both the health plan and the provider.
- Provider networks are built through a complex set of contractual relationships, which include agreement between the health plan and providers on all aspects of the relationship including rate provisions, administrative procedures, claims requirements and payment obligations.
- If a healthcare surge develops, health plans and providers may be challenged to meet their contractual obligations.



Health Plans and Commercial Products (continued)

Payers Volume, Section 2.3

Health Plans and Commercial Products Planning Considerations Table

Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none">• Simplify rate structure for hospitals which may include negotiating a global acute care rate for inpatient care.• Consider providing lump sum advance payments to assist high volume providers in maintaining cash flow.• Consider modifying contract language with independent practice associations/ medical groups and hospitals to provide for an automatic increase in capitation during a surge, when appropriate.• Move toward a common reimbursement, such as a Medicare Diagnosis-Related Group based system to simplify claims generation and payment process.• Consider premium payment deferrals for employer groups with reasonable time frames around premium payments.	<ul style="list-style-type: none">• Modify timely filing provisions to accommodate late or delayed claims.• Proactively develop messaging to communicate surge protocols and administrative procedures.• Accommodate late or delayed premium payments through change in contract language.• Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses.• Create policies to expedite cash flow during a declared healthcare surge.• Consider developing minimum required data elements for reimbursement purposes.• Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility.	<ul style="list-style-type: none">• For closed network models, revise pre-authorization and referral requirements to allow access to care when needed and where available.• Maintain full benefits for members seeking care or accessing care at out-of-network providers due to availability.



Health Plans and Commercial Products (continued)

Payers Volume, Section 2.3

- It may be helpful to review in greater depth the California and federal laws and regulations addressing how health plans can respond to patient care, access and financing issues during a healthcare surge, as well as the types of responses that have occurred historically. To prepare for a healthcare surge, the following rules, requirements, and issues may need to be reviewed and addressed:
 - Physician/network requirements: Issues surrounding which licensed healthcare professional provides services to a member.
 - Pre-authorization: Issues surrounding providing services with or without prior authorization.
 - Pharmaceutical coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions.
 - Co-pay requirements: Issues surrounding member responsibility for co-payments.
 - Nonpayment of premiums and coverage continuity: Issues surrounding non-payment of premiums and termination of coverage.
 - Claims management: Issues surrounding claim payments for members with late or non-current premium payments.
 - Insurance questions and coverage verification: Issues surrounding verifying insurance coverage and other insurance communication needs.



Health Plans and Medicare Advantage Payers Volume, Section 2.4

- Many Medicare eligible individuals, those over the age of 65, some people with disabilities under age 65 and individuals with end stage renal disease voluntarily choose to obtain their healthcare through Medicare Advantage programs.
- Similar to the commercial products, health plans develop networks of providers to provide healthcare services to Medicare Advantage enrollees. The physician and hospital networks are often smaller than those offered under the commercial product and contracts are usually limited to the specific counties where the health plan offers the Medicare Advantage product.
- While historically many hospitals were at financial risk, or paid a per member per month capitation, for a specific population of Medicare Advantage enrollees, the majority of hospitals today are paid a form of fee-for-service reimbursement. Most physician groups and independent practice associations continue to be paid on an 'at risk', or capitated basis.
- Although the administrative and financial issues for health plans administering the Medicare Advantage program are similar to those faced while managing commercial products, Medicare Advantage enrollees pose unique challenges and require that creative solutions be considered during the planning process.



Health Plans and Medicare Advantage (continued)

Payers Volume, Section 2.4



Health Plans and Medicare Advantage Planning Considerations Table

Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> • Simplify rate structure for hospitals which may include negotiating a global acute care rate for inpatient care. • Move toward a common reimbursement, such as a Medicare Diagnosis-Related Group based system to simplify claims generation and payment process. • Since Medicare networks are typically smaller than commercial networks, and across fewer counties, negotiate both professional and facility rates with the commercial network that would apply to Medicare Advantage recipients in the event of a healthcare surge. Focus should be on those geographies where a contracted network does not exist. Establish reciprocity rates for other network providers to access, as well. • Consider providing lump sum advance payments to assist high volume providers in maintaining cash flow. • Consider modifying contract language with medical groups, independent practice associations and hospitals that provide for an automatic increase in capitation during a surge. 	<ul style="list-style-type: none"> • Modify timely filing provisions to accommodate late or delayed claims. • Establish clear messaging for Medicare enrollees during the enrollment process and through ongoing communication related to accessing care during a healthcare surge. • Accommodate late or delayed premium payments through change in contract language. • Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses. • Create policies to expedite cash flow during a declared healthcare surge. • Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate them into their provider contracts. • Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility. 	<ul style="list-style-type: none"> • Consider waiving certain requirements when transferring members from one level of care to another. • During a surge, consider expanding coverage for Medicare Advantage members that would facilitate the movement of patients to skilled nursing facilities and home healthcare. • For closed network models, revise preauthorization and referral requirements to allow access to care when needed. • Maintain full benefits for members seeking care or accessing care at out of network providers due to availability. • Proactively address continuity of care issues for Medicare Advantage members.



Health Plans and Medicare Advantage (continued)

Payers Volume, Section 2.4

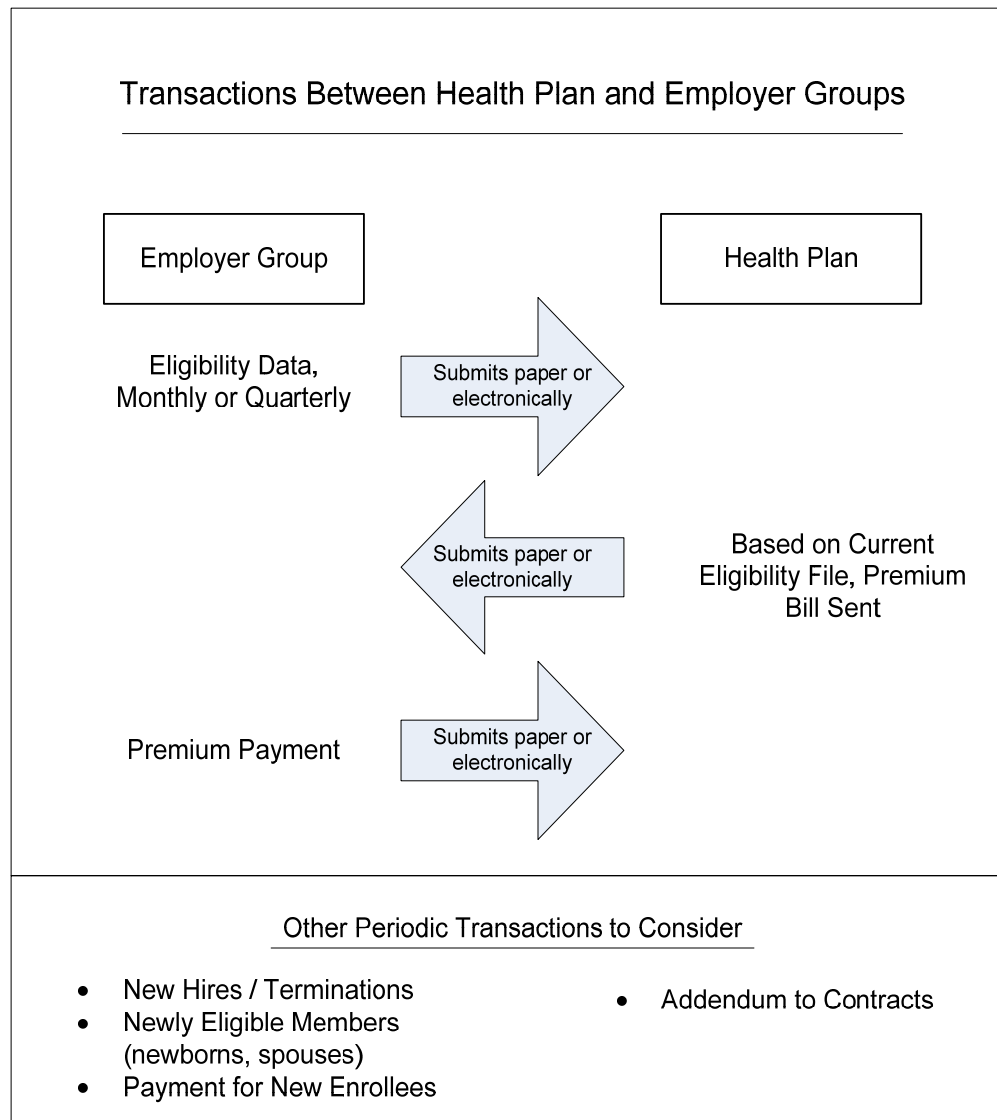
- Similar to dealing with commercial products, one of the challenges in preparing for the financial consequences of a healthcare surge with Medicare Advantage products is the highly situational nature of any healthcare surge response.
- As such, it may be helpful to review in more depth the California and federal laws and regulations indicating how health plans can respond to patient care, access and financing issues during a healthcare surge, as well as the kinds of responses that have occurred in the past. Health plans should be aware of the Medicare regulations and previous response pertaining to the following rules/requirements/issues:
 - Physician/network requirements: Issues surrounding which licensed healthcare professional provides services to a member.
 - Pre-authorization: Issues surrounding providing services with or without prior-authorization.
 - Pharmaceutical coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions.
 - Nonpayment of premiums and coverage continuity: Issues surrounding non-payment of premiums and termination of coverage.



Health Plans and Employers Payers Volume, Section 2.5

The predominant feature of the health plan and employer group relationship is a continuous exchange of information and dollars during the contract term. A healthcare surge may create additional challenges for the health plan since the relationship is transaction based and, in most cases, reliant on the accuracy of the information and access to technology.

The table illustrates certain critical transactions that occur between health plans and employer groups.





Health Plans and Employers (continued) Payers Volume, Section 2.5

- While it is good business practice to establish proper administrative protocols, exchange appropriate information and collect the correct premiums for all eligible members, it becomes critical during a healthcare surge to ensure the flow of dollars from the employer group to the health plan is adequate to reimburse providers treating eligible members.
- Focusing on the key transactions described above, the table below highlights specific issues for a health plan to consider related to employer groups to mitigate risks when working through the planning process.

Health Plans and Employers Planning Considerations Table

Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none">• Consider establishing an average premium level based on eligibility levels at contract inception during the surge period to compensate for lapses in information typically exchanged between the parties.• Establish a streamlined reconciliation process with employer group for those individuals added or deleted during the surge period.	<ul style="list-style-type: none">• If information and payments are typically sent electronically, prepare a process in advance which details a manual process for the exchange of information and payments.	<ul style="list-style-type: none">• Similar to Commercial and Medicare Advantage, consider working proactively with employer groups on plan design changes that would accommodate services typically seen during a surge period.



Health Plans and Medi-Cal Managed Care Payers Volume, Section 2.6

- Several California health plans have contracts in place with Medi-Cal to offer managed care plans to Medi-Cal beneficiaries.
- Currently, three different models operate in 22 counties across California, with Knox-Keene-licensed commercial health plans participating in two of the models, Geographic Managed Care and the Two Plan Model. In the third model, County Organized Health Systems, a county operates the managed care plan and must meet Knox-Keene requirements but does not need a Knox-Keene license. The Two Plan Model was selected to be implemented in counties that had high Medi-Cal populations.
- Unlike commercial networks where a large segment of care is delivered by independent practitioners, many Medi-Cal managed care enrollees are treated within a clinic setting. Therefore, commercial and Medi-Cal networks are often different for the same health plan.
- Like the commercial or Medicare Advantage business, health plans with Medi-Cal Managed Care membership must address similar issues and challenges during a healthcare surge.



Health Plans and Medi-Cal Managed Care (continued)

Payers Volume, Section 2.6

Health Plans and Medi-Cal Managed Care Planning Considerations Table

Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none">• Simplify rate structure for hospitals which may include negotiating a global acute care rate for inpatient care.• Consider providing lump sum advance payments to assist high volume providers in maintaining cash flow.• Consider modifying contract language with independent practice associations / medical groups and hospitals to provide for an automatic increase in capitation during a surge, when appropriate.• Move toward a common reimbursement, such as a Medicare Diagnosis-Related Group based system to simplify claims generation and payment process.• Leverage the health plan's commercial network and negotiate reciprocity rates to accommodate out of network utilization during a healthcare surge.	<ul style="list-style-type: none">• Modify timely filing provisions to accommodate late or delayed claims.• Proactively develop messaging for members to communicate surge protocols and administrative procedures.• Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses.• Create policies to expedite cash flow during a declared healthcare surge.• Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate them into their provider contracts.• Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility.	<ul style="list-style-type: none">• For closed network models, revise preauthorization and referral requirements to allow access to care when needed and where available.• Due to a limited network of providers in some geographies, maintain full benefits for members seeking care or accessing care at out-of-network providers due to availability.



Health Plans and Medi-Cal Managed Care (continued) Payers Volume, Section 2.6

- Similar to dealing with commercial products, one of the challenges in preparing for the financial consequences of a healthcare surge and Medi-Cal Managed Care products is the highly situational nature of any healthcare surge response.
- As such, it may be helpful to review in more depth the California and federal laws and regulations indicating how health plans can respond to patient care, access and financing issues during a healthcare surge, as well as the kinds of responses that have occurred in the past. Health plans should be aware of the Medi-Cal regulations and previous response pertaining to the following rules/requirement/issues:
 - Physician/network requirements: Issues surrounding which licensed healthcare professional provides services to a member.



Health Plans and Workers' Compensation Payers Volume, Section 2.7

- Any injury or illness that occurs during a healthcare surge due to employment would be covered under the employer's workers' compensation policy.
- Workers' Compensation is a significant funding source for health plans to consider because it covers “every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed.”¹ This includes aliens and minors, making it one of the only funding sources to cover the costs of healthcare for individuals not entitled to other programs because of their legal status.
- Some commercial health plans have opted to provide Workers' Compensation products. Unless exempted by law or the employer, all medical care for workers injured on the job whose employer has an approved Medical Provider Network will be provided through the Medical Provider Network.^{2,3}
- Additional guidance on workers' compensation comes from the California Labor Code and is included below as a reference tool for commercial health plans. The tables address the following rules/requirements/issues:
 - Physician/network requirements: Issues surrounding which licensed healthcare professional provides services to a member.
 - Pre-Authorization: Issues surrounding providing services with or without authorization.
 - Utilization: Issues surrounding what care is provided to patients.

¹ Labor Code Section 3351

² <http://igs.berkeley.edu/library/htWorkersCompensation.htm>

³ 8 CCR Section 9767.1



Health Plans and Workers' Compensation (continued) Payers Volume, Section 2.7

During a healthcare surge, some of the Workers' Compensations requirements such as those involving Medical Provider Networks and utilization schedules, may pose challenges. To mitigate these challenges, health plans that manage workers' compensation policies may want to consider the following options:

Health Plans and Workers' Compensation Planning Considerations Table

Policies and Procedures	Access & Coverage
<ul style="list-style-type: none">• Proactively develop messaging for employers and providers to communicate surge protocols and administrative procedures.• Accommodate late or delayed premium payments through change in contract language.• Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses.• Create policies to expedite cash flow during a declared healthcare surge.• Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate these elements into provider contracts.• Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge.	<ul style="list-style-type: none">• Modify utilization schedule requirements to facilitate access to care when needed and where available.• Maintain full benefits for members seeking care or accessing care outside of their designated medical provider network or pre-designated physician.



Minimum Required Data Elements and Templates for Charge Capture

Payers Volume, Section 3.1

Charge capture is the process of collecting charges for services, supplies and pharmaceuticals provided to patients during a healthcare encounter. Maintaining accurate charge capture information allows facilities to properly bill for services, receive reimbursement, and maintain cash flow and business continuity during a healthcare surge.

During a healthcare surge, current electronic methods of charge capture within existing facilities may be unavailable. Additionally, Alternate Care Sites may lack the infrastructure to accommodate electronic systems and the structure to capture charges. Therefore, paper-based methods for capturing charges may be required in both existing and Alternate Care Site facilities.





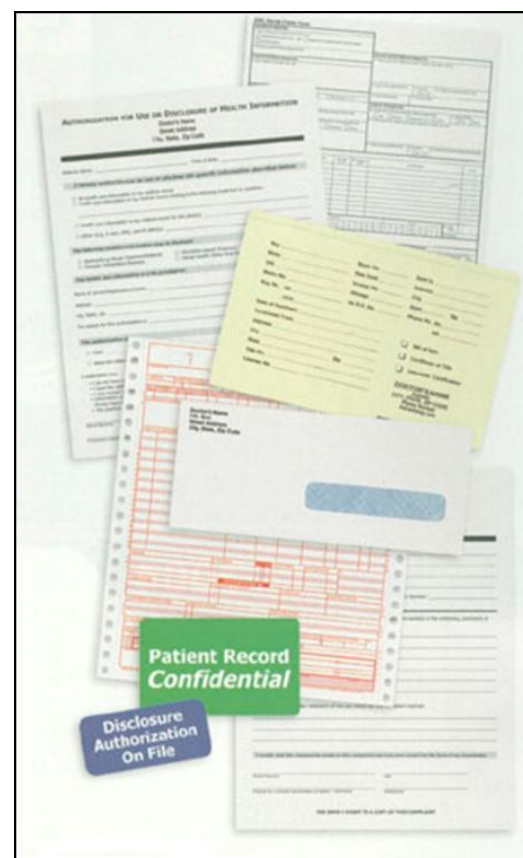
Minimum Required Data Elements and Templates for Charge Capture (continued)

Payers Volume, Section 3.1

The following is a recommended list of minimally required data elements for charge capture that health plans can use to develop and approve minimum data sets for billing that work for their organizations:

Suggested Minimum Requirements:

- Patient name
- Medical record number
- Date of service
- Capture units/dose/quantity
- Department services provided in
- Service description
- Disaster incident number
- Work related injury Y/N





Minimum Required Data Elements for Billing Payers Volume, Section 3.2

- In a healthcare surge, providers may be unable to collect and transmit standard billing data reducing required data elements may become necessary to facilitate payment. As such, it is recommended that health plans develop a list of minimum data elements for billing that works for their organization.
- The minimum data elements are included as recommendations only. Ultimately health plans must agree to accept these recommended minimum data elements from providers for billing purposes.

Institutional Providers Uniform Billing 04 Data Elements	Noninstitutional Providers Centers for Medicare and Medicaid Services 1500 Data Elements
<ul style="list-style-type: none"> •Subscriber Identification/policy number •Time in, time out •Is injury work-related? 1: Provider name, address, phone number 4: Type of bill 8b: Patient name 42: Revenue codes 43: Revenue description 44: Healthcare Common Procedure Coding System rates/codes 46: Units of service 47: Total charges 50: Payer 56: National Provider Identifier 58: Insured's name 67: Principal diagnosis code 69: Admitting diagnosis 74: Principal procedure code 76: Attending 77: Operating 	<ul style="list-style-type: none"> •Subscriber Identification/policy number •Time in, time out •Is injury work-related? 1: Select which payer: Medicare / Medicaid / Champus / Champva / Group Health Plan/ Federal Employees Compensation Act Black Lung / Other 1a: Insured's Identification number 2: Patient name 3: Patient's birth date 5: Patient's address 21: Diagnosis or nature of illness or injury 24 A-G: date of service, place of service, type of service, procedures/services/supplies, diagnosis code, \$ charges, days or units 24K: Use space to include condition code 25: Federal tax Identification number 27: Accept assignment? (yes/no) 28: Total charge 33: Physician's/supplier's billing name, address, zip code & phone number



Additional Billing & Coding Guidance Payers Volume, Section 3.3

The following guidance regarding billing and coding during a disaster can be used by health plans to develop future policies on billing and coding during a healthcare surge:

- **Administrative Simplification Compliance Act Waiver Application¹:** The Administrative Simplification Compliance Act prohibits payment of services or supplies that a provider did not bill to Medicare electronically. The Administrative Simplification Compliance Act Waiver Application allows for flexibility in this rule and stipulates that there are some situations when this requirement could be waived.
- **National Modifier and Condition Code to Be Used to Identify Disaster-Related Claims²:** A new policy was issued establishing a national modifier for providers to use on claims in order to track and facilitate claims processing for individuals affected by the disaster.
- **International Classification of Diseases, Ninth Revision, Clinical Modification Coding for External Causes of Injury³:** In the event of a disaster, coding professionals can use External Cause codes (E codes) to code healthcare encounters and identify the cause of injury(ies) for those affected by the disaster.

¹http://www.cms.hhs.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp#TopOfPage

²<http://www.nubc.org/R1810TN.pdf>

³<http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>



Advancing and Expediting Payment to Provider Payers Volume, Section 3.4

- During a healthcare surge, cash flow may present a significant challenge for large, small and independent providers.
- In many cases, health plans do not have a formalized policy or procedure for advancing or expediting payments, but may have established practice for doing so on an “as needed” basis. Providers may be able to receive advanced or expedited payments by contacting their health plan representatives and discussing these options.
- It is recommended that health plans prepare for the likelihood that providers in need of expedited or advanced payment options will contact their plan partners or program representative directly to discuss advancing and expediting payments and establish memoranda of understanding and protocols in advance or at the time funds are needed.





Other Considerations: California Authority Governing Commercial Health Plans During A Healthcare Surge Payers Volume, Section 4

- Additional authority may be deemed necessary to address the needs of health plans, their members and the community during an emergency. In California, this authority can be exercised through Government Code Sections 8550 and 8567 which permit the Governor to issue “orders and regulations necessary to carry out the provisions of” the Emergency Services Act in order “to protect the health and safety and preserve the lives and property of the people of the state.”¹
- Government Code Section 8571 also grants power to the California Governor “during a state of war emergency or a state of emergency, [to] suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules or regulations of any state agency...where the Governor determines and declares that strict compliance with any statute, order, rule or regulation would in any way prevent, hinder or delay the mitigation of the effects of the emergency.”² Specifically, the Governor could prevent cancellations of policies during an emergency for nonpayment of premiums or prescribe that minimum data fields be used by health plans and providers.

¹Government Code Section 8550

²Government Code Section 8571



The Department of Managed Health Care's Role in a Healthcare Surge

Payers Volume, Section 4.1

- The Department of Managed Health Care licenses and regulates Health Maintenance Organizations, Preferred Provider Organizations and discount plans in California governed under the Health and Safety Codes and 28 CCR. Specifically, the Department of Managed Health Care and its Director:
 - “Have charge of the execution of the laws of this state relating to healthcare service plans and the healthcare service plan business....”¹
 - “Are responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department.”²
 - Have rule making and order making authority to “... adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of ... [the Knox-Keene Act].
 - May waive any requirement of any rule or form in situations where in the director’s discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to ... [the Knox-Keene Act].”³

¹ Health and Safety Code Section 1341(a)

² Health and Safety Code Section 1341(c)

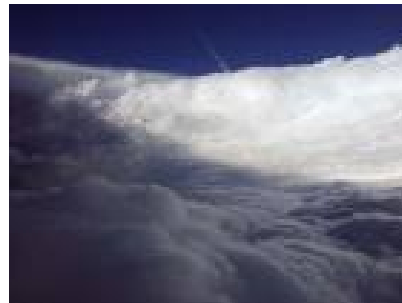
³ Health and Safety Code Section 1344(a)



The Department of Managed Health Care's Role in a Healthcare Surge (continued)

Payers Volume, Section 4.1

- In order to cope proactively with healthcare surges resulting from disaster or states of emergency, responsibility for protection of enrollees may necessitate:
 - Keeping healthcare services available to enrollees.
 - Keeping the revenue stream flowing to providers in order to keep healthcare services available.
 - Transferring enrollees from plan-to-plan in the event of diminished plan capacity to keep healthcare services available.
 - Transferring provider capacity from plan-to-plan to mitigate a shortage of healthcare services in severely impaired geographic areas.





The Department of Managed Health Care's Role in a Healthcare Surge (continued)

Payers Volume, Section 4.1

- Depending upon the nature, breadth, and severity of a “state of emergency,” the statutory and order making powers of the Director of the Department of Managed Health Care may not be sufficient to protect enrollees adequately. Certain powers may have to be ordered or delegated by the Governor.
- Such executive orders may include the Governor granting a limited transfer of authority to the Director of the Department of Managed Health Care to issue emergency rules and orders applying to healthcare service plans licensed by the Department of Managed Health Care.
- This limited transfer of authority would authorize the Director to suspend certain statutes, regulations and healthcare service plan contract provisions and take other actions in order to facilitate mitigation of the emergency and healthcare surge, as indicated by the severity of the emergency.
- Such delegated authority may be exercised by the Director in whole or in part and from time-to-time, depending upon the severity and duration of the healthcare surge, the state of emergency, and the need to ensure that healthcare service plans provide enrollees with access to healthcare services and that enrollees’ interests are protected.



The Department of Managed Health Care's Role in a Healthcare Surge (continued)

Payers Volume, Section 4.1

- It may be helpful for health plans to understand in more detail the specific kinds of actions the Department of Managed Health Care may take under its delegated authority. Awareness of these actions may enable health plans to more adequately prepare their staff and organizations for mandated healthcare surge responses by providing the opportunity to incorporate these mandates into their own response plans.
- Under its delegated authority the Department of Managed Health Care may take any of the following actions:
 - **To protect enrollees' access to healthcare services:** Ensuring that enrollees of healthcare service plans have access to healthcare services.
 - **To manage financial risk:** Managing healthcare service plan financial risk during healthcare surge.
 - **To manage continuation of provider services:** Assuring continuation of provider services and protection of providers.
 - **To seek federal waivers:** The Director of the Department of Managed Health Care in cooperation with the Director of DHCS may request that the Governor request federal waivers and uncompensated care pool from the federal government.



Payers Volume Wrap Up

Now that you have completed this training course, you should now be able to:

- List general health plan and provider planning considerations, including charge capture and billing recommendations, which should be discussed in advance through contract provisions.
- Differentiate between product-specific planning considerations and suggested guidelines for managing commercial, Medicare Advantage and Medi-Cal Managed Care business.
- Describe the California authority governing health plans during a healthcare surge.