MANAGED CARE SURVEY

CALIFORNIA ASSOCIATION OF HEALTH FACILITIES

CAHF

2022

ABOUT THE SURVEY

The Managed Care Survey for 2022 offers insight into the challenges and opportunities faced by skilled nursing facilities as they work with managed care plans with a focus on issues associated with CalAIM, the Medi-Cal carve-in, which will begin throughout the state on January 1, 2023. This study was initiated in 2015, and offers trends in provider attitudes towards managed care payors and overall satisfaction with health plans, focusing primarily on reimbursement issues.

CalAIM will have a major impact on CAHF members since with the elimination of fee-for service Medi-Cal, managed care plans will be the primary payor source for all providers in every county. We hope the concerns identified in this survey will result in further discussions and opportunities for improvement as skilled nursing providers transition to CalAIM.

2. REPRESENTING 527 BUILDINGS THROUGHOUT CALIFORNIA

1. WHAT TYPES OF ORGANIZATIONS ARE REPRESENTED IN THIS SURVEY?

13%

Own and operate one or more facilities with less than 500 beds

48%

Own and operate 2 or more facilities with 500 beds or more

9%

Billing company

30%

Other

3. ACCOUNTS RECEIVABLE OPERATION STRUCTURE

Survey participants were asked to disclose how their facilities' accounts receivable operations are structured.

39% Corporate oversight with most processes conducted at facility level

30% Process is structured with centralized billing under corporate control

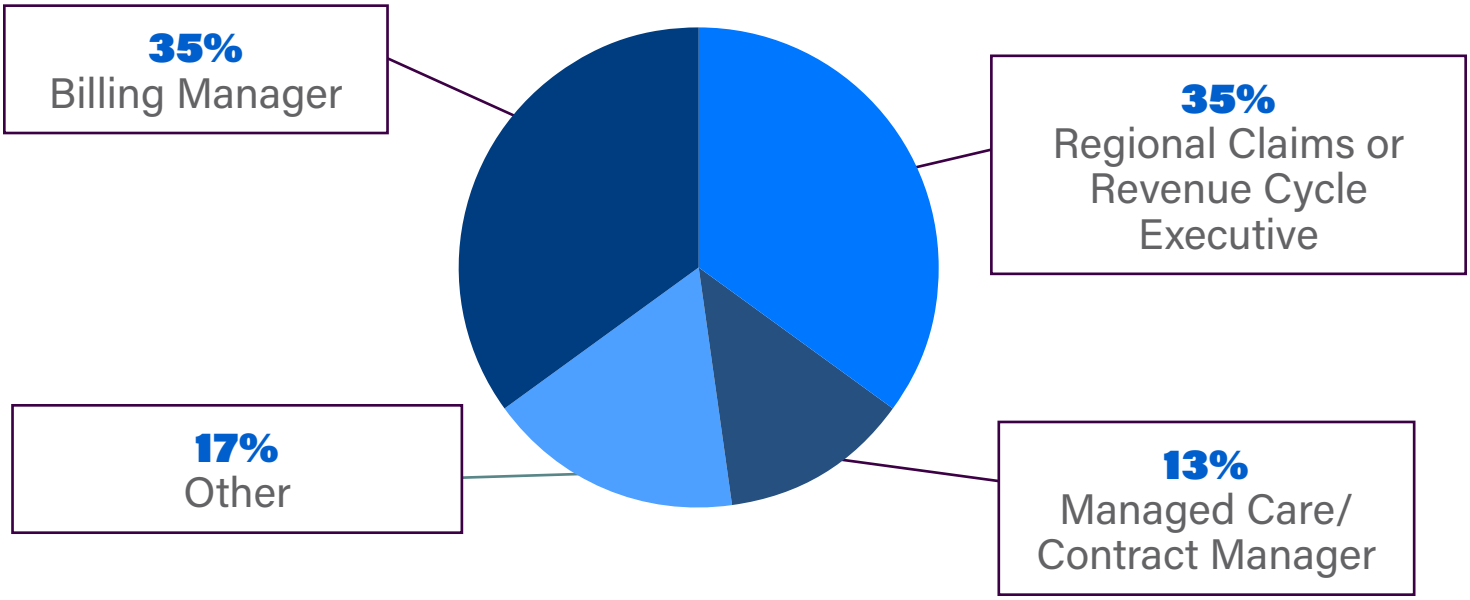
13% All AR processes conducted at the facility

4% Billing is outsourced

13% Other

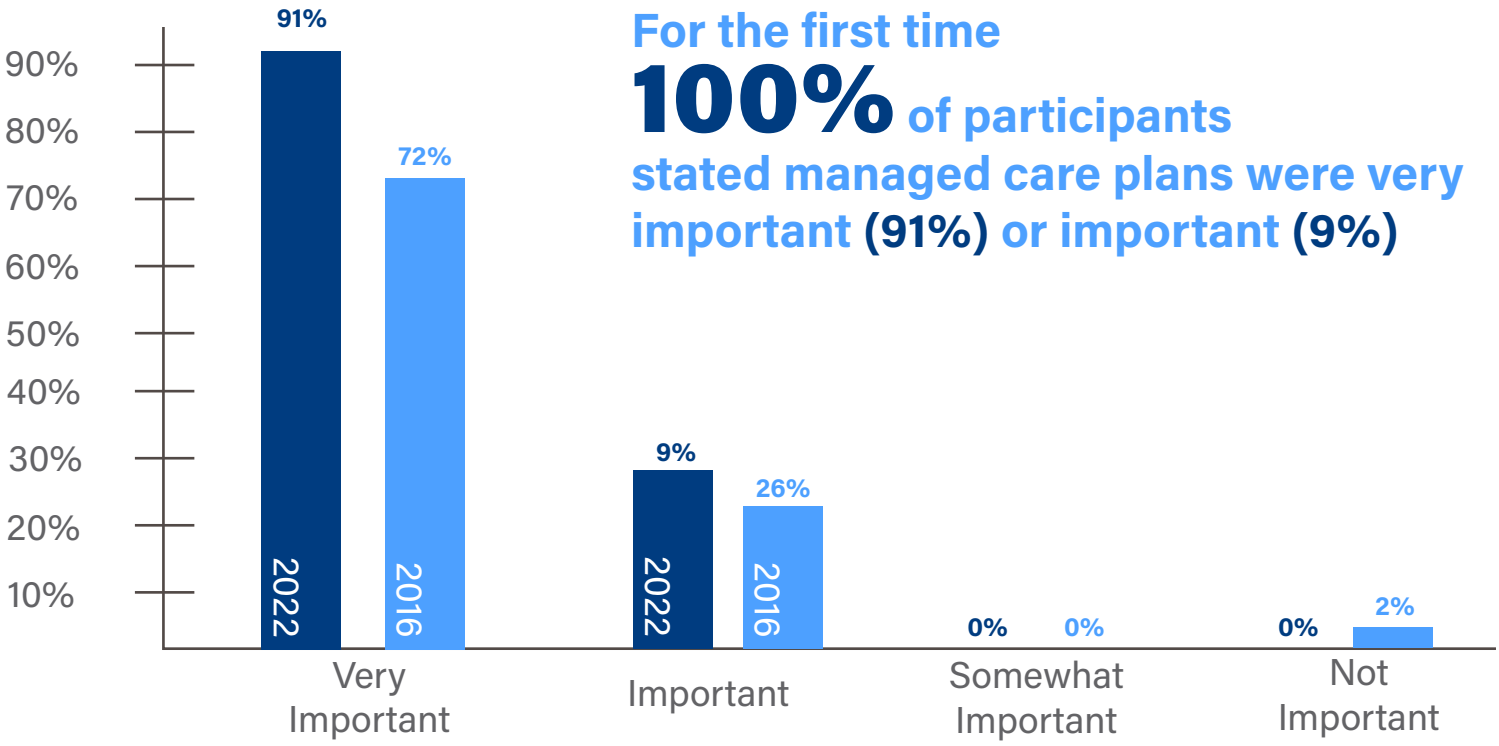
4. SURVEY PARTICIPANT ROLES & RESPONSIBILITIES

Participants were asked to disclose their role within the company/facility.



5. IMPORTANCE OF MANAGED CARE

Survey participants were asked to rank the importance of Medicare and Medi-Cal managed care.

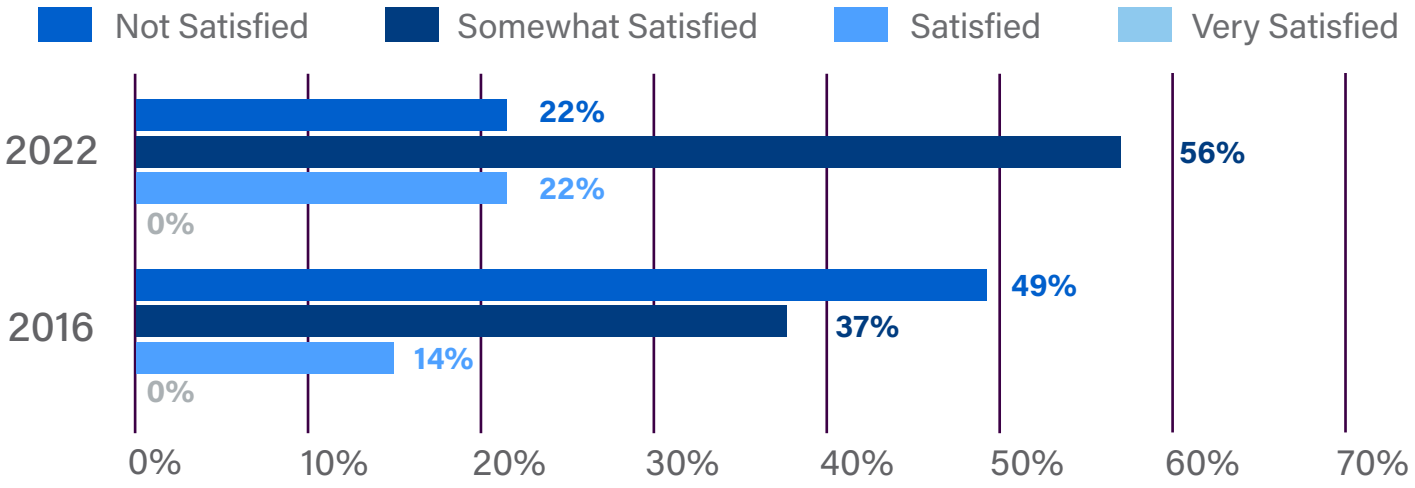


For the first time

100% of participants stated managed care plans were very important (91%) or important (9%)

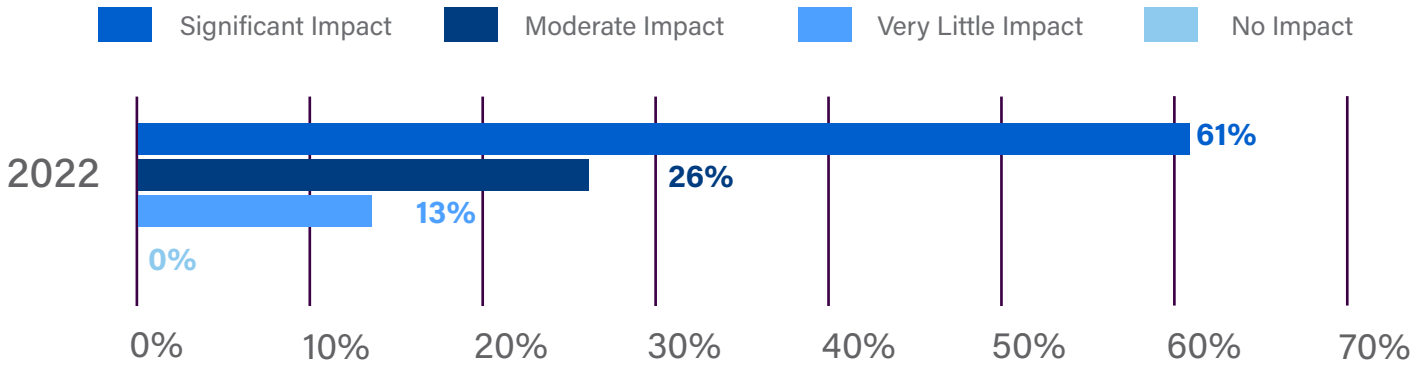
6. MANAGED CARE SATISFACTION

This year, 22% of respondents were "satisfied" with their managed care plans, which is the highest score achieved in the nine years of data collection.



7. CalAIM IMPACT ON ORGANIZATION

Survey participants were asked the impact of CalAIM on their organization.



8. ENOUGH INFORMATION FOR SUCCESSFUL CalAIM IMPLEMENTATION

There are significant concerns that not enough information has been shared by the state to implement CalAIM successfully. Survey participants commented:

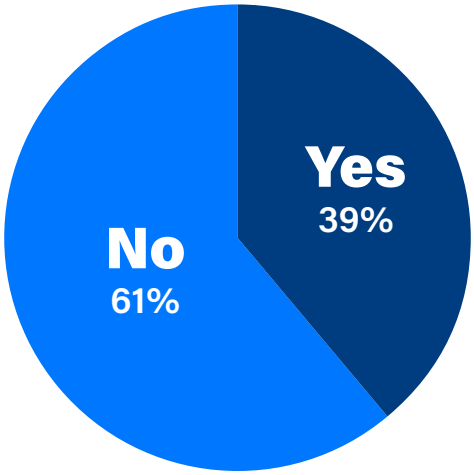
"No, typically the state does not do anything to assist when the providers are not authorized or paid correctly from the plans."

"We know a lot, but the state hasn't clearly spelled out the details for providers."

"Have not received much detail regarding transition date eligibility changes."

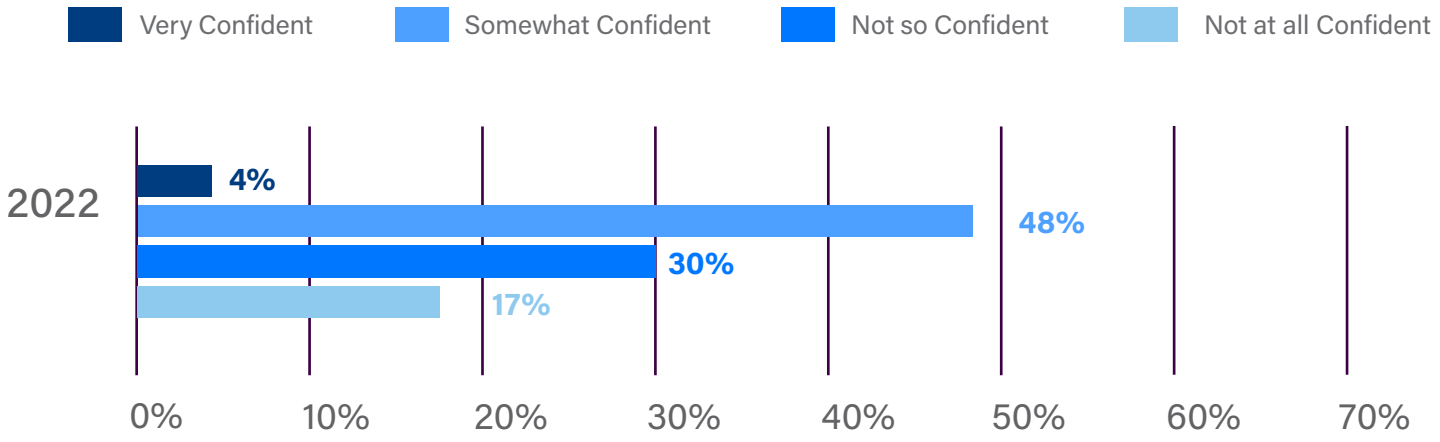
"Since the plans will not be prepared, no matter what the facilities do to prepare will not matter."

"Still so many questions to be answered!"



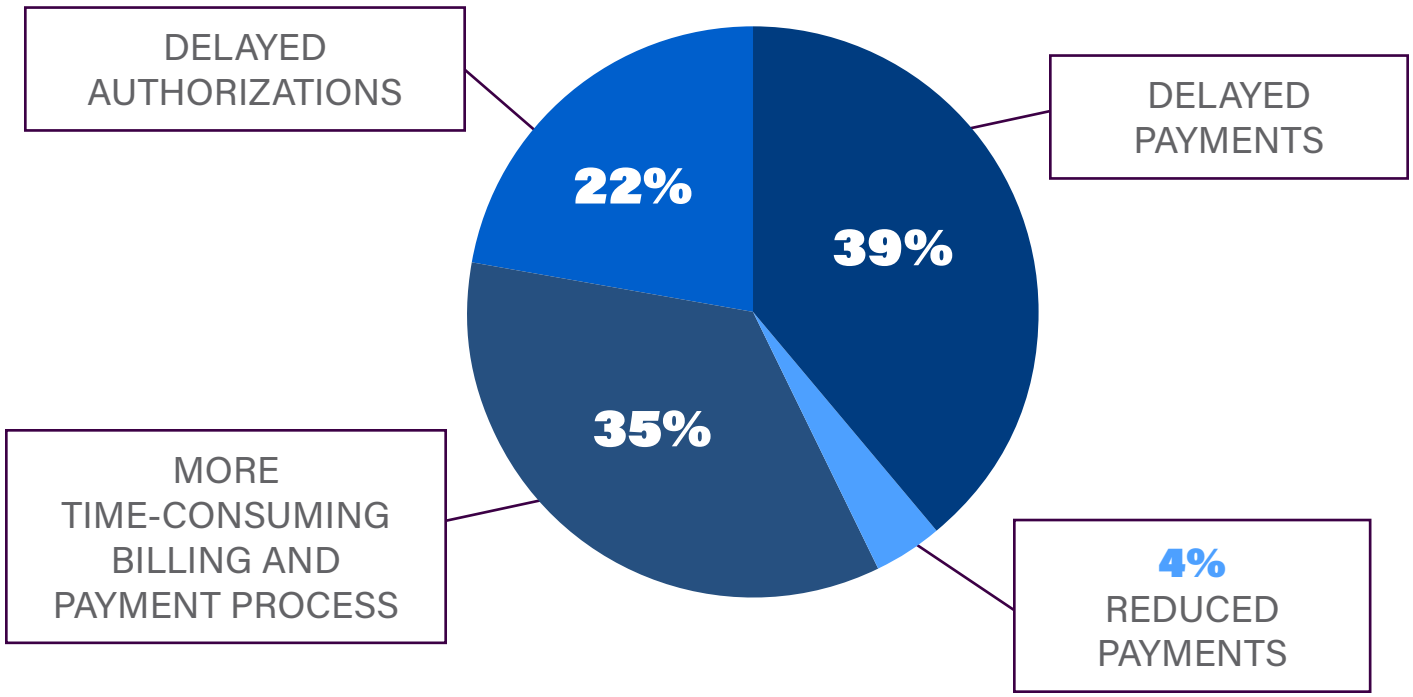
9. ABILITY TO HELP FACILITATE A SUCCESSFUL CalAIM TRANSITION

Confidence in the health plan's ability to help vary by county, with 52% somewhat confident or very confident in the plan's ability to assist with the transition.



10. CONCERNS WITH CalAIM TRANSITION

Participants weighed their concerns relative to the CalAIM transition.



11. OTHER CONCERNS ABOUT CalAIM

Participants' responses:

- Reduced payments and reduced length of stay. Identifying individuals who do not meet criteria and stopping payment even though there is no safe place for the individual to go.
- Delayed systems while in introduction phase including auths, payments and more time consuming billing and claims follow up. Plans are having difficult times now with staffing, how are they going to have the staff available to implement such a significant shift in care?
- Authorization delays
- Different rules for different payors make the job harder and it will be difficult to collect timely and get paid correctly.
- Delayed authorizations will impact census and delay payments, creating cashflow issues.
- Eligibility issues
- Processes currently under CCI are still not clean and streamlined for all Medi-Cal plans. Plans still have no clue how to do rate adjustments! Anticipating more of the same start up issues and delayed payments.
- Verifying accuracy of eligibility & member enrollment, chasing authorizations, inaccurate payment (i.e. not deducting share of cost or non-covered services properly).
- Lack of communication with managed care plans
- No standardized policies equal to those provided by fee-for-service Medi-Cal will result in continued problems and confusion.
- Plans not understanding SNF processes, LTC benefits, delayed or denied authorizations, denied claims, delayed payments, erroneous recoupments. Everything we have experienced with CCI all over again.
- Will the plans be ready to handle SNF claims? Will there be uniform billing between the plans? What will the authorization process be?
- Concerns include reduced payments, reduced census, more time spent trying to get paid, delayed authorizations and certain plans not paying at all for certain types of providers.
- Payment reductions due to passive contracts and uncompetitive rates for skilled Medi-Cal members.

12. PAYMENT TIMELINESS

CAHF members were asked to rate their satisfaction with payment timeliness for each health plan. Medi-Cal and Medicare fee-for-service are tracked to compare health plan payment with the payment timeliness of fee-for-service payors. The ratings with the highest number of responses are in **bold**.

ANTHEM	
Poor	14%
Fair	**52%**
Good	33%
Great	0%

BLUE SHIELD /PROMISE	
Poor	26%
Fair	**42%**
Good	32%
Great	0%

CAL OPTIMA	
Poor	7%
Fair	14%
Good	**58%**
Great	21%

CHG SAN DIEGO	
Poor	18%
Fair	27%
Good	**45%**
Great	9%

GOLD COAST	
Poor	17%
Fair	**33%**
Good	**33%**
Great	17%

HEALTH NET	
Poor	14%
Fair	31%
Good	**45%**
Great	10%

IEHP	
Poor	0%
Fair	14%
Good	**57%**
Great	29%

KAISER	
Poor	17%
Fair	33%
Good	**44%**
Great	6%

L.A. CARE	
Poor	24%
Fair	**41%**
Good	35%
Great	0%

MOLINA	
Poor	29%
Fair	**38%**
Good	29%
Great	5%

SANTA CLARA FAMILY HEALTH PLAN	
Poor	44%
Fair	0%
Good	**56%**
Great	0%

PARTNERSHIP HEALTH PLAN OF CA	
Poor	0%
Fair	31%
Good	**54%**
Great	15%

MEDI-CAL (FFS)	
Poor	0%
Fair	10%
Good	19%
Great	**71%**

MEDI-CARE (FFS)	
Poor	0%
Fair	5%
Good	19%
Great	**76%**

The health plans rated highest for timeliness are local plans **IEHP (86% "good" or "great") and Cal Optima (86% "good" or "great"), while Medi-Cal (91% "good" or "great") and Medicare (95% "good" or "great") are perceived as faster payors.**

13. PAYMENT ACCURACY

Participants were asked to rate satisfaction with each plan's payment accuracy. The ratings with the highest number of responses are in **bold.**

ANTHEM		BLUE SHIELD /PROMISE		CAL OPTIMA		CHG SAN DIEGO	
Poor	23%	**Poor**	**56%**	Poor	7%	Poor	0%
Fair	**55%**	Fair	22%	Fair	14%	Fair	36%
Good	18%	Good	17%	**Good**	**50%**	**Good**	**45%**
Great	5%	Great	5%	Great	29%	Great	18%

GOLD COAST		HEALTH NET		IEHP		KAISER	
Poor	10%	Poor	19%	Poor	7%	Poor	15%
Fair	**40%**	Fair	33%	Fair	20%	Fair	25%
Good	20%	**Good**	**43%**	**Good**	**47%**	**Good**	**55%**
Great	30%	Great	5%	Great	27%	Great	5%

L.A. CARE		MOLINA		SANTA CLARA FAMILY HEALTH PLAN		PARTNERSHIP HEALTH PLAN OF CA	
Poor	33%	Poor	29%	Poor	11%	Poor	0%
Fair	**39%**	**Fair**	**43%**	**Fair**	**44%**	Fair	31%
Good	22%	Good	29%	**Good**	**44%**	**Good**	**54%**
Great	6%	Great	0%	Great	0%	Great	15%

MEDI-CAL (FFS)		MEDI-CARE (FFS)	
Poor	5%	Poor	0%
Fair	10%	Fair	10%
Good	19%	Good	24%
Great	**67%**	**Great**	**67%**

Cal Optima had 79% of respondents rate them as "good or "great," and IEHP had 74% providers note they are "good" or "great" on payment accuracy. Anthem and Blue Shield Promise had the lowest rating in this category.

14. COMMUNICATION & FOLLOW UP

Participants were asked to rate their satisfaction with communication and follow up.

	2022		2021	
ANTHEM	**Poor**	**50%**	**Poor**	**30%**
	Fair	41%	**Fair**	**30%**
	Good	9%	**Good**	**30%**
	Great	0%	Great	9%
BLUE SHIELD /PROMISE	**Poor**	**71%**	Poor	7%
	Fair	18%	**Fair**	**47%**
	Good	12%	Good	40%
	Great	0%	Great	7%
CAL OPTIMA	Poor	14%	Poor	7%
	Fair	21%	**Fair**	**47%**
	Good	**57%**	Good	40%
	Great	7%	Great	7%
CHG SAN DIEGO	**Poor**	**50%**	Poor	27%
	Fair	10%	**Fair**	**36%**
	Good	30%	Good	27%
	Great	10%	Great	9%
GOLD COAST	**Poor**	**40%**	Poor	18%
	Fair	20%	Fair	18%
	Good	30%	**Good**	**54%**
	Great	10%	Great	9%
HEALTH NET	Poor	14%	Poor	22%
	Fair	38%	**Fair**	**35%**
	Good	**43%**	**Good**	**35%**
	Great	5%	Great	9%
IEHP	Poor	20%	Poor	6%
	Fair	7%	Fair	29%
	Good	**60%**	**Good**	**41%**
	Great	13%	Great	23%
KAISER	Poor	26%	Poor	9%
	Fair	26%	**Fair**	**52%**
	Good	**42%**	Good	33%
	Great	5%	Great	5%
L.A. CARE	**Poor**	**41%**	Poor	12%
	Fair	35%	**Fair**	**41%**
	Good	24%	Good	29%
	Great	0%	Great	18%
MOLINA	**Poor**	**45%**	**Poor**	**52%**
	Fair	40%	Fair	17%
	Good	15%	Good	26%
	Great	0%	Great	4%
SANTA CLARA FAMILY HEALTH PLAN	Poor	33%	Poor	20%
	Fair	22%	Fair	20%
	Good	**44%**	**Good**	**60%**
	Great	0%	Great	0%
PARTNERSHIP HEALTH PLAN OF CA	Poor	15%	Poor	0%
	Fair	15%	Fair	29%
	Good	**62%**	**Good**	**47%**
	Great	8%	Great	24%

For 6 of the 12 health plans surveyed, communication and follow-up deteriorated in 2022 (vs 2021), perhaps due to staffing issues or employees transitioning to home-based work.

Blue Shield Promise has the greatest opportunity for improvement with 71% rating the plan "poor" in this critical area.

15. MANAGING CONTRACT UPDATES & AMENDMENTS

Participants were asked to rate satisfaction with the contracting process. Ratings with the highest number of responses are in **bold.**

ANTHEM	
Poor	**50%**
Fair	19%
Good	31%
Great	0%

BLUE SHIELD /PROMISE	
Poor	**80%**
Fair	0%
Good	13%
Great	7%

CAL OPTIMA	
Poor	18%
Fair	9%
Good	**36%**
Great	**36%**

CHG SAN DIEGO	
Poor	**36%**
Fair	27%
Good	27%
Great	9%

GOLD COAST	
Poor	**57%**
Fair	0%
Good	29%
Great	14%

HEALTH NET	
Poor	25%
Fair	**50%**
Good	19%
Great	6%

IEHP	
Poor	33%
Fair	**42%**
Good	25%
Great	0%

KAISER	
Poor	27%
Fair	**33%**
Good	**33%**
Great	7%

L.A. CARE	
Poor	**38%**
Fair	**38%**
Good	24%
Great	0%

MOLINA	
Poor	**50%**
Fair	19%
Good	31%
Great	0%

SANTA CLARA FAMILY HEALTH PLAN	
Poor	**43%**
Fair	14%
Good	**43%**
Great	0%

PARTNERSHIP HEALTH PLAN OF CA	
Poor	25%
Fair	25%
Good	**38%**
Great	12%

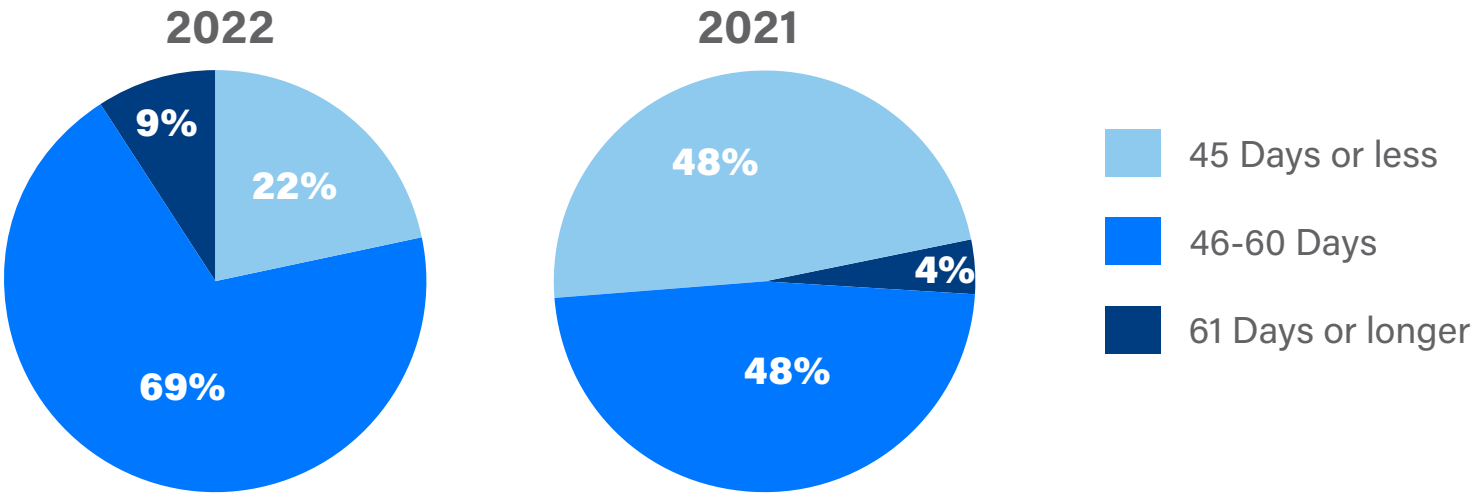
MEDI-CAL (FFS)	
Poor	11%
Fair	0%
Good	33%
Great	**55%**

MEDI-CARE (FFS)	
Poor	0%
Fair	11%
Good	33%
Great	**55%**

Last year, 5 of the 12 health plans in the survey were ranked "good" or "great" by more than 50% of respondents. This year, only Cal Optima and Partnership Health Plan met that threshold.

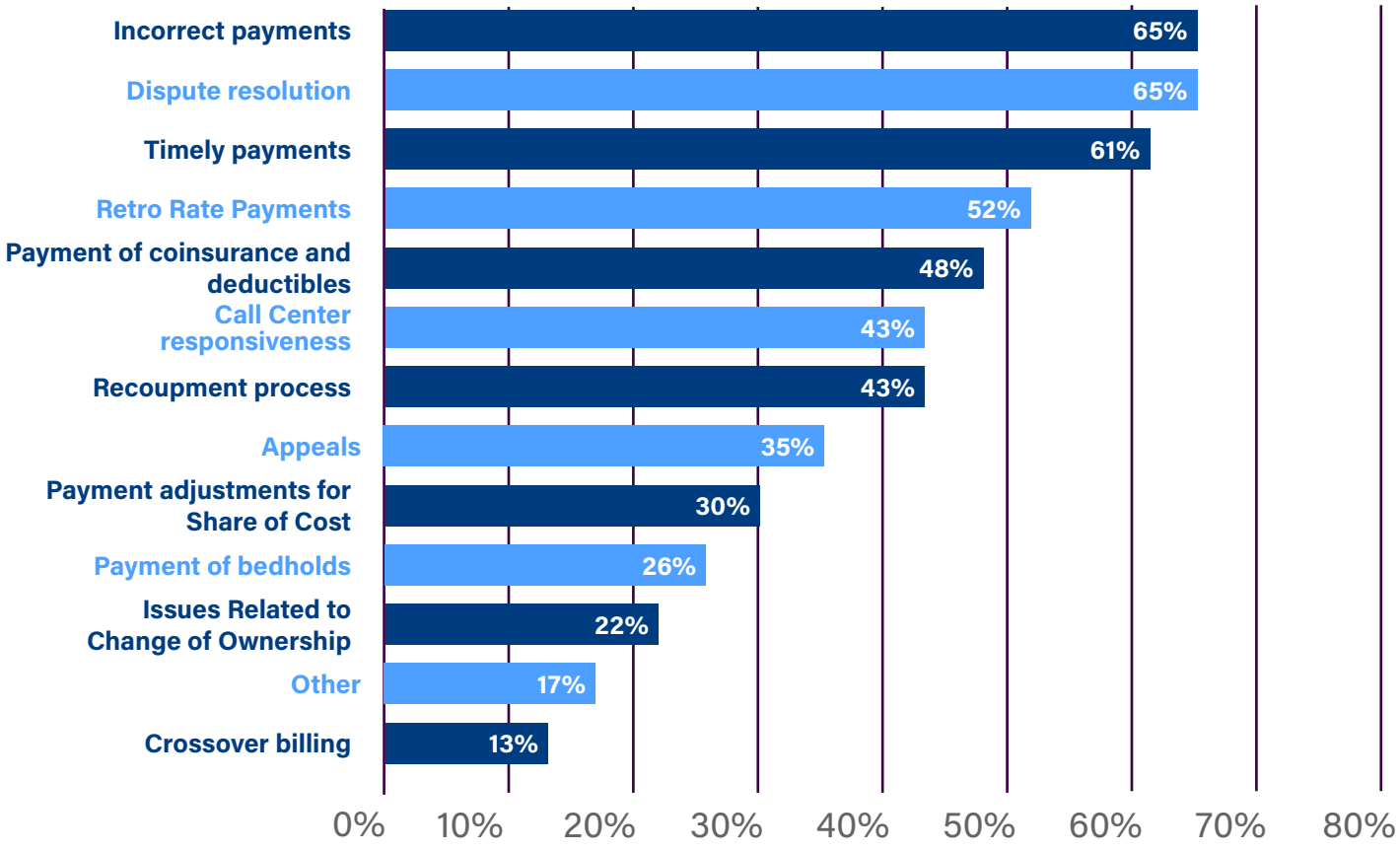
16. PAYMENT RECEIVABLES & DELAYS

Overall payment delays continue to be a problem, with **78% of providers stating it takes more than 45 days for health plans to pay claims, up from 52% in 2021.**



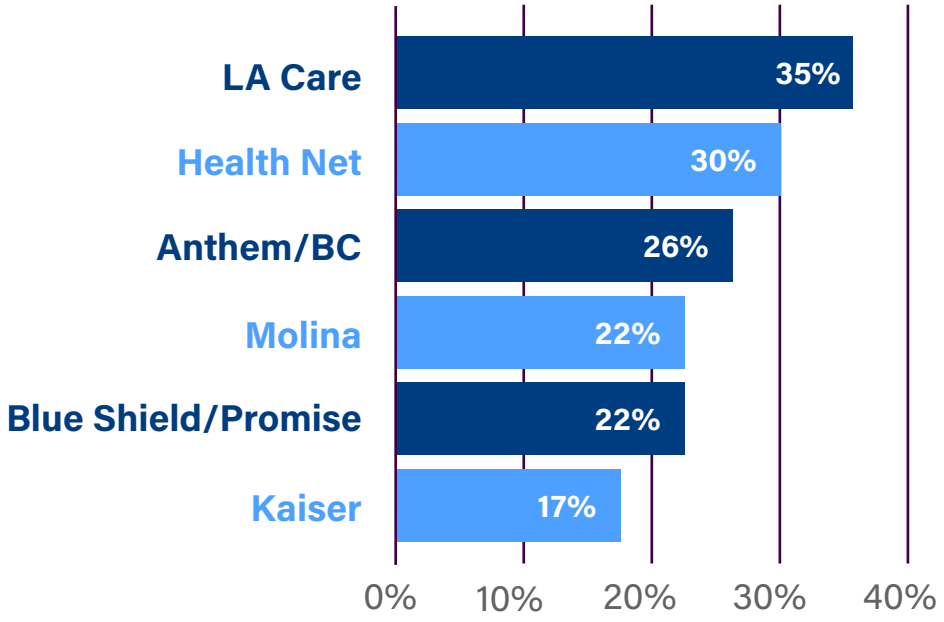
17. PROBLEMS WITH MANAGED CARE

Survey respondents revealed the main problems their facilities have experienced with managed care in the last two months.



18. GREATEST AMOUNT OF OUTSTANDING RECEIVABLES

Although 10 plans were noted at least once, as expected, the larger plans tend to have higher accounts receivable. Total exceeds 100% since providers noted more than one plan with outstanding receivables. The summary below shows the plans that providers identified as having the greatest amount of outstanding AR.



19. MOST RESPONSIVE TO NEEDS OF CAHF PROVIDERS

2022	2016
IEHP	Health Net
Partnership Health Plan	Kaiser
LA Care/Kaiser	Care First
	IEHP

20. LEAST RESPONSIVE TO NEEDS OF CAHF PROVIDERS

2022	2016
LA Care	Molina
Molina	LA Care
Anthem	Anthem

21. CASE MANAGERS

Providers reported their satisfaction with the case managers for each health plan. Overall, there were fewer responses for this question since many of the respondents are off site and/or are not in a position to rate this issue.

Cal Optima, Gold Coast & Partnership Health Plan have the highest rates of satisfaction with case managers.

ANTHEM		BLUE SHIELD /PROMISE		CAL OPTIMA		CHG SAN DIEGO	
Poor	38%	Poor	36%	Poor	0%	Poor	0%
Fair	**46%**	**Fair**	**64%**	Fair	33%	**Fair**	**63%**
Good	15%	Good	0%	**Good**	**67%**	Good	38%

GOLD COAST		HEALTH NET		IEHP		KAISER	
Poor	0%	Poor	15%	Poor	10%	Poor	0%
Fair	**50%**	**Fair**	**54%**	**Fair**	**50%**	**Fair**	**58%**
Good	**50%**	Good	31%	Good	40%	Good	42%

L.A. CARE		MOLINA		SANTA CLARA FAMILY HEALTH PLAN		PARTNERSHIP HEALTH PLAN OF CA	
Poor	20%	Poor	36%	Poor	0%	Poor	0%
Fair	**60%**	**Fair**	**43%**	**Fair**	**80%**	**Fair**	**56%**
Good	20%	Good	21%	Good	20%	Good	44%

22. PROVIDER RELATIONS

Respondents rated their satisfaction with provider relations or other primary contact at each plan.

Gold Coast, IEHP and Partnership have the highest satisfaction rates.

ANTHEM	
Poor	**47%**
Fair	33%
Good	20%

BLUE SHIELD /PROMISE	
Poor	**69%**
Fair	31%
Good	0%

CAL OPTIMA	
Poor	9%
Fair	**45%**
Good	**45%**

CHG SAN DIEGO	
Poor	**40%**
Fair	**40%**
Good	20%

GOLD COAST	
Poor	25%
Fair	25%
Good	**50%**

HEALTH NET	
Poor	21%
Fair	**43%**
Good	36%

IEHP	
Poor	15%
Fair	31%
Good	**54%**

KAISER	
Poor	8%
Fair	**62%**
Good	30%

L.A. CARE	
Poor	**33%**
Fair	**33%**
Good	**33%**

MOLINA	
Poor	**47%**
Fair	33%
Good	20%

SANTA CLARA FAMILY HEALTH PLAN	
Poor	29%
Fair	**57%**
Good	14%

PARTNERSHIP HEALTH PLAN OF CA	
Poor	9%
Fair	**45%**
Good	**45%**

23. DELEGATED ENTITIES

Sixty one percent of respondents stated they work with delegated entities (IPAs, at risk hospitals, ACOs, etc.) associated with managed care health plans. Delegated entities have resulted in payment delays above and beyond what the providers experience with health plans as shown in Q 26.

24. MOST RESPONSIVE

Medpoint

Of the four delegated entities cited as being responsive, only Medpoint was noted more than once. Brown & Toland, Pioneer Provider Network and Sutter DCE were each mentioned once, but the most frequent response was "none".

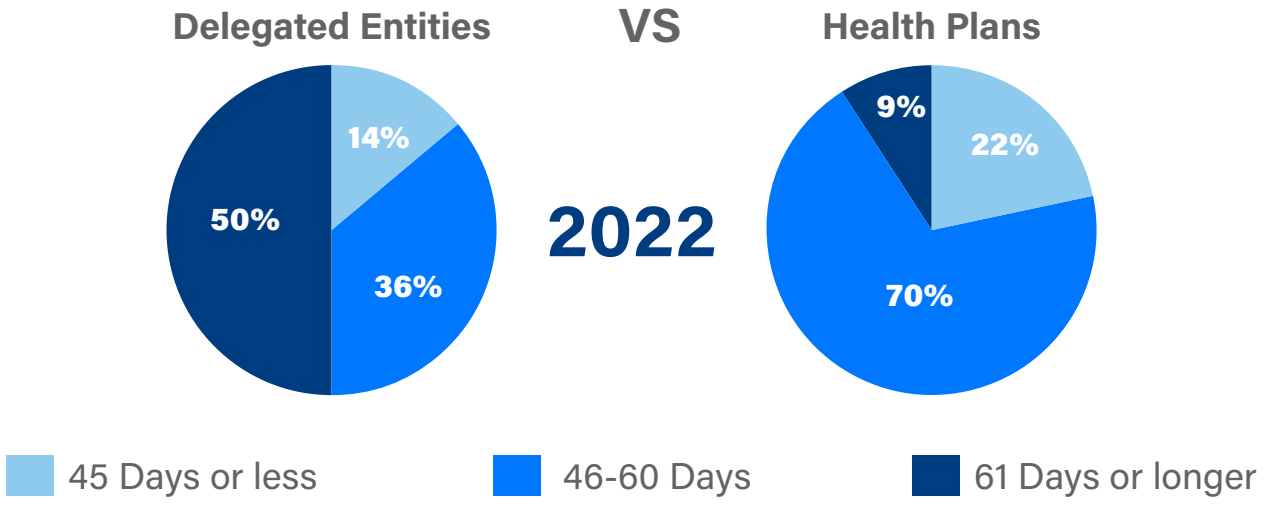
25. LEAST RESPONSIVE

Primecare

There are 15 delegated entities cited as the least responsive and only Primecare was noted more than once. There continue to be many problems as many delegated entities still seem unsure of their fiscal responsibilities in the post-acute care setting.

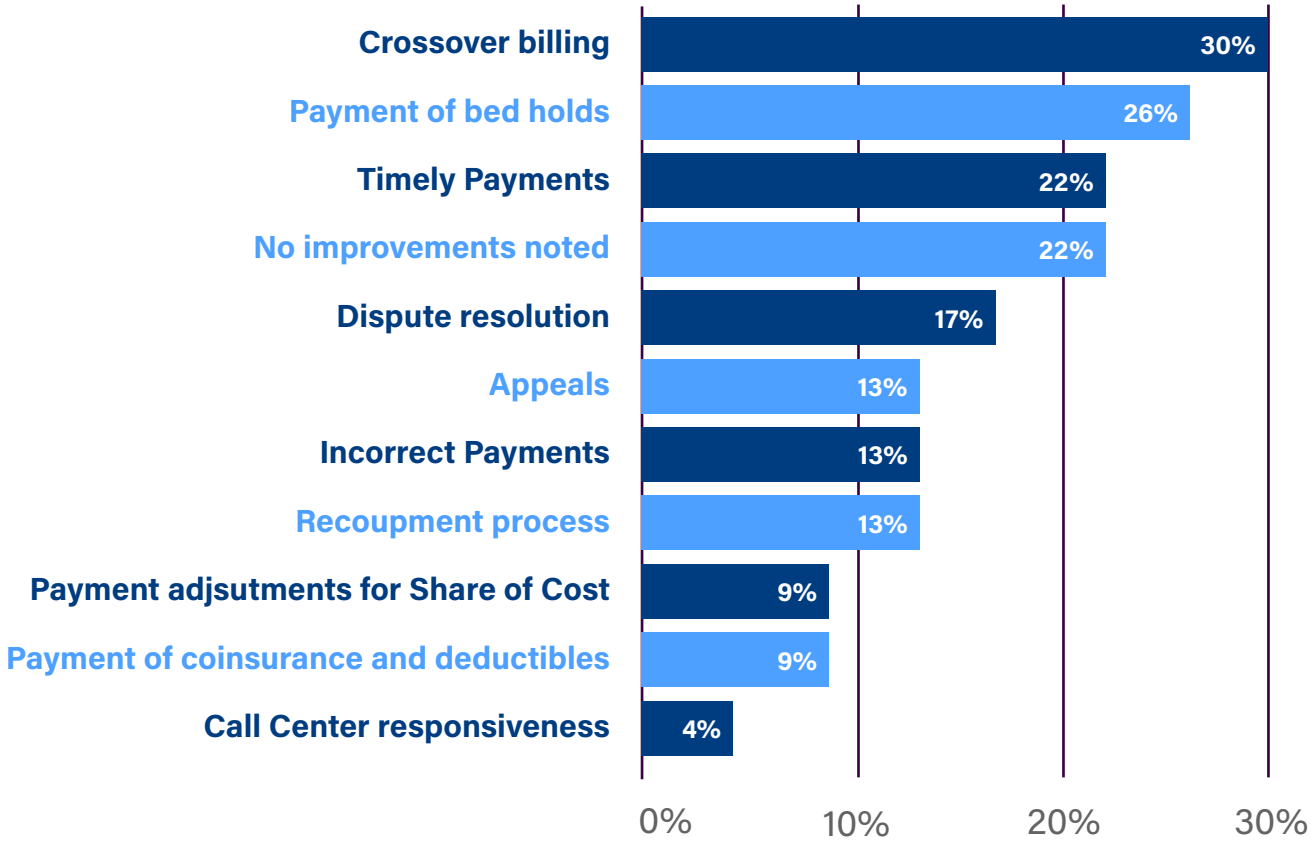
26. PAYMENT DELAYS

There continue to be significant unresolved payment delays for delegated entities, with **50% of respondents stating it takes them over 60 days to pay claims.** This issue needs further attention.



27. IMPROVEMENTS IN REVENUE CYCLE

Respondents were asked to list any items that have improved in the last 6 months with respect to their managed care revenue cycle.



28. RECOMMENDED IMPROVEMENTS

Providers were asked to make recommendations to plans in order to improve the revenue cycle process.

Although 49 recommendations were received, they fell into a few major categories:

TIMELY PAYMENT

- Process claims by following timeliness guidelines of Medicare & Medi-Cal.
- Payment delays often result from billing delays that occur because of auth delays. A quicker response to authorization would help.
- Learn to process retro rates timely & accurately.

TRAINED STAFF

- Need form knowledgeable support from call centers.
- Train staff so they understand SNF claims issues/experienced customer service personnel.
- When processes change, the staff needs to be trained.
- Additional claims assistance (some payors allow only 1 question per call).

28. RECOMMENDED IMPROVEMENTS

CONTINUED

PAYMENT ACCURACY

- Plans working with NaviHealth is of great concern. They modify payment and ignore MDS completion of section GG. This is not acceptable.
- Update contracts in your system once signed.
- Timely system updates would improve payment accuracy.
- Make user friendly tools available for determining risk arrangements between plans and IPAs.
- More transparency on fiscal responsibilities.
- Provide clear reason for denials so claims can be quickly reprocessed .

RETRO PAYMENTS

- Provide a plan for retro payments so we have a timeline.

AUTHORIZATION PROCESS

- Plans need to clearly state the auth process and follow up in a timely manner.
- Improve portals to include authorizations, claims, PDRs etc.
- Delayed authorizations cause delayed billing
- Include approved level of care on the authorization.
- Provide written auths pre-admissions concurrently from both the health plans and the delegated entities, especially important with Navihealth.

APPEALS

- Process appeals timely

COMMUNICATION

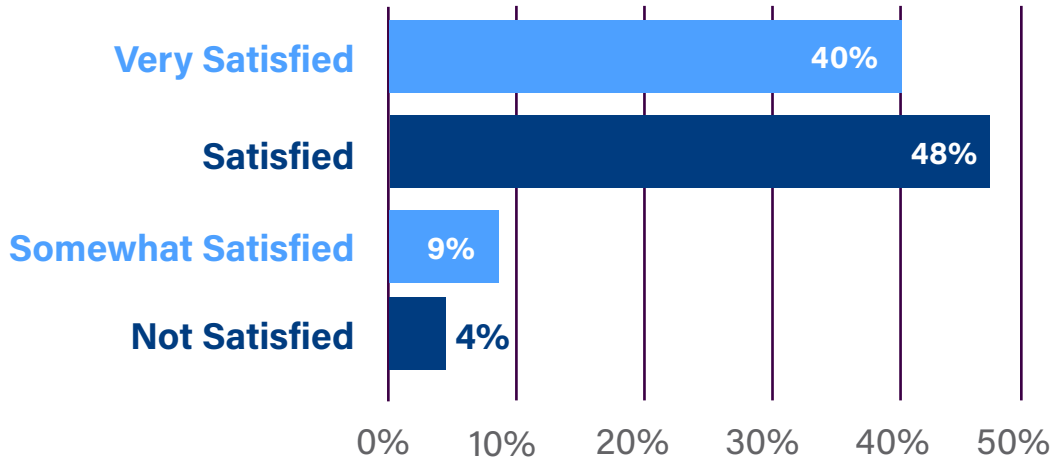
- Need updated list of contact people at plans.
- Hold more webinars and training (particularly in light of CalAIM).
- Need detailed explanation of denials to avoid future problems or having to call for that information.
- Clarify escalation process to claims management.
- Make it easier to call versus going to an automated voicemail to get the right person and taking hours to get issues resolved.
- Notify providers when billing processes are changed.
- If you say you are going to follow up, follow up!
- Improve portals to provide more information so we do not have to reach out to staff that often does not understand our claims issues.

CONTRACTING

- Review time frames for contract rollouts. Contract delays are very time consuming.
- Contract language should align with DHCS regulations and delete language that does not apply to skilled nursing facility providers.
- Contracts with significant problems and errors are identified and plans frequently state they can't modify the contract or fix errors because contacts have been approved by DHCS. There must be a way to assure contract language is compliant.
- Contracts often include language that does not align with DHCS regulations and language that does not apply to skilled nursing facility providers.
- When contracts with significant problems or errors are identified, health plans frequently state the language cannot be modified since the contracts have been approved by DHCS.

29. SATISFACTION WITH CAHF SERVICES AND RESOURCES RELATED TO MANAGED CARE

Members are **mostly satisfied** and **very satisfied** by services and resources offered by CAHF in support of managed care issues and the revenue cycle process.



30. IMPROVING THE REVENUE CYCLE PROCESS

Members provided the following feedback to CAHF to improve the support for managed care issues and the revenue cycle process. Responses include:

- Influence the state more to listen to the concerns of SNFs and for the managed care plans to respond.
- Create training slides for CalAIM SNF rollout for facility IDT's. Monthly push for plan meetings with operators.
- More info on CalAIM.
- Have legal representation communicate with DHCS and plans on failures.
- Send updates as contacts at plans change.
- Send updates as billing process changes with plans.
- Meet with plan CEOs and CFOs to ensure they know what is happening and push harder to make changes.
- More actions and solutions to members concerns.
- Facilitate more collaborative meetings with plans.
- Demand compliance with electronic billing requirements.
- Appreciate legislative updates and CAHF's continued support with the industry changes.
- Continue your wonderful efforts and connect us at a higher level with the health plans.
- CAHF does a great job overall.

CALIFORNIA ASSOCIATION
CAHF
OF HEALTH FACILITIES

Founded in 1950, the California Association of Health Facilities is a non-profit professional organization representing nearly 900 skilled nursing facilities and 450 intermediate care facilities for individuals with intellectual disabilities. Each year more than 147,000 caregivers provide short-term rehabilitation, long-term care, end-of-life assistance and habilitative nursing services for 400,000 people. CAHF is the largest provider of continuing education for long-term care professionals in California, facilitating continuous quality improvement for our providers and improved outcomes for our residents.

For more information, contact:

Karen Widerynski
Managed Care Specialist, CAHF

kwiderynski@cahf.org
562-253-1445