CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

Department of Health Care Services
California Advancing and Innovating Medi-Cal (CalAIM)

TITLE: How Medi-Cal managed Care Supports Subacute Care Facility and ICF/DD Home Residents Webinar

DATE: Friday, December 15, 2023, 9:00AM to 10:00AM

NUMBER OF SPEAKERS: 5

FILE DURATION: 57:10

SPEAKERS

Kristal Vardaman
Bambi Cisneros
Dr. Laura Miller
Noelle Simonick
Tyler Brennan

Kristal Vardaman:

I'll go ahead. Good morning and thank you all for joining today's webinar, CalAIM: How Medi-Cal Managed Care Supports Subacute Care Facility and ICF/DD Home Residents. This session is part of the educational webinar series about the Subacute and ICF/DD Carve-Ins. A few things to note before we begin: the webinar is being recorded and the recording and the slides will be posted to the DHCS Subacute Care Facility and ICF/DD LTC Carve-In webpages shortly after today's presentation. Participants are currently in listen only mode, but can be unmuted during the Q&A periods. In order to participate in the Q&A, please use the Raise Hand feature and our team will unmute you. You can also use the chat feature to submit questions, so please feel free to type any questions into the chat during the presentation as we'll be monitoring them. Next slide please. And just a bit of housekeeping before we get started.

Kristal Vardaman:

We'd ask that you take a minute now to add your organization's name to your Zoom name so that it appears as your name plus your organization, and that will help us track any questions if we need to follow up. So, in order to do this, click on the “Participants” icon at the bottom of the Zoom window. Hover over your name on the participant's list on the right side and select “Rename”. And so you can then enter your name and add your organization as you like it to appear. Next slide please. So here's our agenda today. First, we're going to provide an overview of the ICF/DD and Subacute Care Facility Carve-Ins. Then we'll be spending most of our time reviewing key benefits provided by Medi-Cal managed care plans. We'll also have several opportunities for Q&A throughout the presentation. And finally, we'll close with next steps and additional resources. And now I'll turn it over to Bambi Cisneros to do the Long-Term Care Carve-In overview.

Bambi Cisneros:

Great, thank you, Kristal. Good morning, everyone. Thanks for joining us this morning. So I will give a brief overview of the Long-Term Care Carve-In and then we'll spend most of our time today discussing the various ways that managed care plans can support members, not just while they are in the facilities and Homes, but as well as other services that plans offer to really provide that whole person care. And so we can go to the next slide, please. Thank you. So as a refresh, the Long-Term Care Carve-In is part of CalAIM's benefit standardization initiative. And so that means the goal is to standardize benefits coverage statewide to ease the administrative burden experience for providers as well as improve the member experience.

Bambi Cisneros:

So the Long-Term Care Carve-In implementation is on a phased approach. So part one, which occurred on January 1, 2023 is when managed care plans in all counties began covering Skilled Nursing Facilities services. And then part two, which includes the Subacute Care Facilities and Intermediate Care Facilities for the Developmentally Disabled, or ICF/DDs, will occur on January 1, 2024. The Department did release All

Plan Letters on each of these topics as guidance to managed care plans on these policies, which we have linked here on this slide.

Bambi Cisneros:

Next slide please. I had mentioned standardization in the previous slide and that's because coverage for ICF/DD and Subacute Care services currently vary depending on the county where the member lives today. But starting on January 1, 2024, all Medi-Cal members that are living or staying in an ICF/DD, ICF/DD-H, and ICF/DD-N Homes or Subacute Care Facilities will be enrolled in a Medi-Cal managed care plan for their Medi-Cal covered services. Thank you. And again, the goals of the Long-Term Care Carve-In are to standardize Long-Term Care services coverage under managed care statewide. And by doing so, we anticipate that there will be less complexity and increased access for members to have access to comprehensive care coordination and care management services that the plans offer, which we'll walk through in later slides this morning. And of course, our topline goal is that the transition will be as seamless as possible and that members will not experience any gaps in care. And so, with that, I will now transition to Dr. Laura Miller with our Quality and Population Health Management division to talk about Medi-Cal Managed Care benefits.

Dr. Laura Miller:

Great, thank you Bambi, and good morning to everybody. It is Friday, we're moving into holiday times, so I'm going to be spending a fair amount of time talking about Medi-Cal Managed Care benefits. Next slide please. And I really think of this as an array of benefits and these are the topics that we're going to be talking about today. Basic Population Health Management – and again, I think of this as what every single member needs to get – access to medical care, access to wellness and prevention. Complex Care Management for people with complex needs. Enhanced Care Management, which is really the top tier of folks in specific populations of focus who need very intensive care management, Transitional Care Services when a person is moving from one care setting to another. And then my colleagues will be speaking about Community Supports as well as transportation. Next slide.

Dr. Laura Miller:

So, I'll first talk about Population Health Management. Population Health Management, or PHM, aims to establish a comprehensive accountable plan of action for addressing member needs and preferences across the continuum of care. Super important. It's about building trust and meaningfully engaging members. Within the scope of health management we think about gathering, sharing, and assessing timely and accurate data on member preferences to identify benefits and services that they need. We also connect members to preventive care and other care management as well as reducing health disparities by linking members to public health and social services that address their health-related social needs. And I think this is a key piece here, this last one around the social drivers of health. We definitely, what happens within the four walls of a clinic is a tiny amount of a person's life and we really want to address the whole person by broadening out our conception of care to really address social needs.

Dr. Laura Miller:

So, I mentioned this before, I think of this sort of as a tier of services on the Medi-Cal managed care plan care management continuum. So, ECM is for members with the highest needs, Complex Care Management for members with higher and medium to rising risk. In my primary care practice, I often think about the rising risk, let us support people so that their diseases do not worsen. And then the Basic Population Health Management for all Medi-Cal members, and transitional care for anybody when they are transitioning between settings. We all know that things can fall apart with those transitions and the goal of the Transitional Care Services are to really support members as they go through transitions and their families and have things not fall through the cracks. Next slide.

Dr. Laura Miller:

So, we'll dive a little bit more into Population Health Management. As a part of Population Health Management, managed care plans are required to have a broad range of programs and supports to meet the needs of all members. And we group the programs and supports in the following three areas. So, there's Basic Population Health Management. Again, this is engagement with primary care, care coordination and referrals, wellness, and prevention. Then care management services. This includes Complex Care Management and Enhanced Care Management that we've talked about before. And then Transitional Care Services when members are transitioning from one setting to another. Next slide.

Dr. Laura Miller:

So, we'll dive in a little deeper on Basic Pop Health Management. And again, it's an approach to care that ensures that needed programs and support are made available to each member, regardless of their risk tier, at the right time, in the right setting to address their health and health related needs. In my primary care practice, we care for the people who come in the building, but really we need to conceive of Basic Population Health Management as taking care of the whole population, hence Population Health Management. So key components include access, utilization, and engagement of primary care, care coordination and referrals to all health and social services, information sharing and referral infrastructure. Super important. Our data systems help us remain siloed and we're really working hard to break down those silos and have appropriate information sharing so that people don't have to be the carriers of their information.

Dr. Laura Miller:

They do not need to be the carrier pigeons bringing things back and forth to various providers. We want to integrate Community Health Workers. This is an incredibly important workforce. We want access to wellness and prevention programs as well as addressing chronic disease, and absolutely important are maternal health outcomes. We have a great deal of disparity in racial and ethnic groups, regards maternal health outcomes and we really want to address that. And of course, Population Health Management for children. Within Basic Population Health Management, health

education and cultural and linguistic programs along with linkages to public health schools and social service programs, these are foundational for the effective delivery of Basic Population Health Management. I will note that these components aren't new and many are included in the NCQA Population Health Management standards. But what is new is that DHCS is now articulating them as a comprehensive package of programs and supports for members and really trying to make sure that these services are delivered to all members. Next slide.

Dr. Laura Miller:

So, we're going to dive into Complex Care Management. That's the middle tier, if you will. So DHCS established a common terminology and set of expectations that apply across populations who need care management, establishing a continuum of care between care management approaches, including Complex Care Management and Enhanced Care Management. So, we use the term Complex Care Management. This equates to the term Complex Case Management as defined by NCQA. It is for higher and medium to rising risk members. It includes chronic care management and interventions for episodic temporary needs. It must include comprehensive assessment of the member and adhere to all of the NCQA Population Health Management chronic case management requirements. And in this instance, Medi-Cal managed care plans can use their own staff as case managers. And I think that's a key point. There's a distinction with Enhanced Care Management. Next slide. So we're going to dive into ECM.

Dr. Laura Miller:

So Enhanced Care Management is a statewide Medi-Cal managed care plan benefit to support comprehensive care management for members with complex needs. The vision is for ECM to coordinate all care for eligible members in all of our systems. The physical health, behavioral health, dental health, all of those pieces, as well as linking members to social supports. It is interdisciplinary, high touch, and provided primarily through in-person interactions where we are really reaching members where they live, seek care, or prefer to access their services. And it's really the highest tier of care management. If you think about the pyramid of a population, ECM is for the tippy top.

Dr. Laura Miller:

Core services include outreach and engagement, comprehensive assessment and care management plan, enhanced coordination of care, coordination and referral to community and social support services, member and family supports. I think that's incredibly important. ECM is not meant to be a multi-year program in the life of an individual. So we really want to have that member and their family empowered to be able to continue all of the linkages that ECM is promoting. Of course, we want to do health promotion and education and when an ECM member is in another setting, i.e. hospital or skilled nursing, we want really exquisite transitional care for them as they transition from one setting to another. Next slide.

Dr. Laura Miller:

So, we're going to dive in now to ECM in the context of ICF/DD and Subacute Care facility residents. So, members who currently live in an ICF/DD Home are not currently eligible for ECM. But if there are other individual care needs or concerns, their needs can be reviewed for consideration, and that review would happen with the managed care plan. Members residing in Subacute Care facilities are also excluded from ECM during their stay on the basis that the care that they're receiving the facility is comprehensive and highly specialized. It's really important to note that if a member transitions out of an ICF/DD Home or Subacute Care facility, that restriction regarding duplicative services is removed and the member can be assessed to determine if they are eligible for ECM services. So again, in the design of this benefit, we were really thinking about what services do people need and how and where are they getting them. I see the one chat that I can respond to while talking, ECM is Enhanced Care Management. It is the highest tier, the most intensive tier of care management offered by the Medi-Cal plans for their members. Next slide.

Dr. Laura Miller:

So, I'm going to move to talk a little bit about Transitional Care Services. Again, Transitional Care Services are for when a member is transitioning from one clinical setting to another, like hospital to Home, hospital to skilled nursing, skilled nursing to Home. Next slide. So as part of the PHM program, plans must provide strengthened Transitional Care Services. So as of January 1, 2024, MCPs must ensure that prior authorization determinations are rendered in a timely manner for all members and plans must have a process to track when members are admitted, discharged, or transferred from facilities including ICF/DD Homes and Subacute Care Facilities. Next slide.

Dr. Laura Miller:

So, in terms of an overview of transitional care services. To define it, transitional care happens when a member transfers from one setting to another, including but not limited to discharges from hospitals, institutions, other acute care facilities and skilled nursing facilities to home or community-based settings. So really any transition. The goals are to have the member be able to transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner and without interruptions to care. We want members to receive the needed support and coordination to have a safe and secure transition with the least burden on the member as possible. And members, we want that members continue to have the needed support and connections to services that make them successful in their new environment. Next slide.

Dr. Laura Miller:

So to summarize Transitional Care Services policies for '24 and '25, in October of '23, DHCS released the updated Population Health Management Policy Guide with modified guidance on Transitional Care Services. So the general requirements are to know when a member is admitted, discharged, or transferred, to process prior authorizations in a timely manner, and when possible, prior to discharge, and identify members that belong to the high risk and lower risk groups for transitional services. So that's at a high level,

the managed care plan responsibility. Next slide. For high risk members, then this is a clarification. We want the plan, as the responsible entity, to assign or notify a single point of contact or care manager. If the member is enrolled in CCM or ECM, the assigned care manager must be the lead care manager with ECM or the Complex Care Manager. Again, if somebody is in ECM or CCM, a person in that program, a provider knows them and knows their issues.

Dr. Laura Miller:

And that's the reason for this designation if somebody is in CCM or ECM. The assigned care manager should receive and review the discharging facility's discharge information and ensure that it is shared with a member and the post-discharge providers. So all of these responsibilities below are with the care manager. We want the care manager to complete all follow-ups, including ensuring the completion of medication reconciliation and any follow-ups to doctor appointments or referrals to social services or community organizations. And then if a member is not already in ECM, CCM, or receiving Community Supports, we want to make sure that that referral happens within 30 days after discharge. And then Transitional Care Services ends when all needs are met, which can be up to 30 days or longer. Or the member is enrolled in ongoing care management programs like CCM and ECM. Next slide.

Dr. Laura Miller:

So I'm now going to review requirements for the lower risk members transitioning who are in Transitional Care Services. So the Medi-Cal plan or their delegate must have a dedicated team or phone number for member contract. And they must ensure that members who are transitioning from one setting to another have that number to call and connect to a Transitional Care Services team who can access the discharge documents if needed. The discharge planning process is done with the facility and the managed care plan in concert. So the managed care plan must oversee and ensure that facilities complete a discharge planning process in accordance with federal and state requirements. The Medi-Cal plan or their delegate must assure that ambulatory follow-up appointment is completed within 30 days for post-discharge care and services including medication reconciliation.

Dr. Laura Miller:

Again, this is extremely important. Med lists often get completely scrambled in these transitions. And the medications a member receives are crucially important. We want that the plan or delegate, evaluate and refer members for all of these programs, ECM, CCM, and CS. And we want to ensure that the discharging facilities also know how to do this. And then TCS and enrollment in Care Management. The plan must continue to offer TCS support through the telephonic team for at least at least 30 days after discharge. Again, building a very clear and comprehensive safety net for folks in that period after transition from one care setting to another. Next slide.

Dr. Laura Miller:

So in terms of Care Coordination, we want to highlight some additional requirements when it comes to Care Coordination, specifically for ICF/DD members, since these members also receive Care Coordination and support from their assigned Regional Center. So, for Medi-Cal members residing in ICF/DD Homes, the plans are required to coordinate and work with Regional Centers when identifying services provided to members by the plans. The Regional Center coordinator will continue to be the ICF/DD member's primary source for accessing services and resources identified in the Individual Program Plan. Plans and Regional Centers will also need to coordinate if a member wishes to transition to a different living arrangement following leave of absence or a bed hold.

Dr. Laura Miller:

So, if the member wants to transition to a non-Medi-Cal funded living situation, the Regional Center will take the lead. And if the member chooses to transition to a different Medi-Cal level of care, the plan will take the lead on discharge and transition planning in collaboration with the Regional Center. Care Coordination processes between Regional Centers and managed care plans will be agreed upon and documented in a Memorandum of Understanding that they're required to execute. And there are details about this MOU that are in the APL 23-029 and the hyperlink is in the deck. So now I'll turn it back to Kristal from Aurrera who will lead our first Q&A. And I definitely saw questions flying in the chat but could not attend to them on the fly.

Kristal Vardaman:

Yes, thank you Dr. Miller. So we've had a number of questions in the chat. I know there's some being responded to by folks on the DHCS team as well. We're going to start off with questions that relate to Dr. Miller's presentation. I see there's some other questions on other topics as well. So we'll start there and then open up for some other questions before we move on to the next segment. Let's see. So one question that's come in from Devora. Do care managers find placement for members such as nursing homes or do discharge notices include when a member is being evicted?

Dr. Laura Miller:

Two questions, let's talk about them separately. In the instance when a member is in the hospital, it is a shared responsibility with the hospital case manager and the plan, it really is shared. The hospital case manager is there, they have lots of linkages out with Skilled Nursing Facilities, et cetera. So it's a shared responsibility. With regards to eviction, that does not fall in the admitted discharge and transferred bucket. And you're right to call that out. The admission discharge and transfer, or ADT, is very much within the medical settings, not the setting of eviction. It's a really good call out, but eviction is not thought of in this particular workflow.

Kristal Vardaman:

Okay, thank you. And another follow-up question from your presentation. Laurie asks, when you're referring to ICF/DD Homes, does that include the DD-H and DD-N Homes?

Dr. Laura Miller:

It does. It does, yes.

Kristal Vardaman:

Okay. Another question that's come in: Is each MCP going to assign a specific case manager to each ICF/DD facility and/or each client residing in the ICF/DD?

Dr. Laura Miller:

You know, I don't know. My guess is that that would be plan dependent in terms of how they operationalize it, but I certainly, if anyone else on the DHCS team knows better, I certainly welcome them to come off camera and let me know. My guess is that it's plan dependent in terms of how they manage their staffing.

Kristal Vardaman:

Okay. I see Bambi's come up.

Bambi Cisneros:

No, I didn't have any further. I agree with Laura. I think it's plan specific.

Kristal Vardaman:

Great. I see another question that just came in the chat. Are the TCS care managers expected to be involved in the discharge planning process while the member is in the hospital or SNF?

Dr. Laura Miller:

They are. Yes. Yes. Because that's where, I mean, that is where the transition starts is in that acute care setting. So yes, discharge planning begins at admission, as we always say.

Kristal Vardaman:

Okay. Another question that's in the chat: how are these groups of managed care going to be working with the nurse and the ICF/DD? And it sounds like this is a nurse who's already, this is something that they already are doing.

Dr. Laura Miller:

I'm sorry, can you... I missed that.

Kristal Vardaman:

Yes, and Valerie, if you want to raise your hand, we can bring you off mute if you could, to maybe add some additional detail. But the question again is how are these groups of managed care going to be... Valerie's got her hand up, so we'll unmute you, Valerie, so you can provide some additional details. I think you should be unmuted now.

Valerie Parker:

Okay. So, I already manage their coordination between Home and hospital, their ICF/DD Homes, they go in the hospital, I deal with the transfer. If they have to go to rehab, I deal with rehab when they come home. I'm trying to understand where all these other parts are going to come in. It's part of my job to deal with all this. So I'm just trying to understand how that's going to work.

Dr. Laura Miller:

I think a lot of it is that this is now added support and plan-centered support for you doing all those pieces, and perhaps more of a direct line to the plan through that Transitional Care Manager to make sure that things don't fall through the cracks. So you are a partner in it, no one is taking away that function that you have and that you're doing in what sounds like a beautiful fashion for your members. And you will have a plan partner who can leverage things from within the plan that might've been harder to leverage prior, if that makes sense.

Valerie Parker:

Okay. I've never had issues, so I don't know.

Dr. Laura Miller:

Oh, I'm delighted. That's great. And I think I've definitely seen that there's often many challenges with transitional care. So I think these local relationships that are going to be building over the next years will be really important. But I'm delighted that you haven't had big challenges. That's wonderful.

Valerie Parker:

Thank you.

Kristal Vardaman:

Dr. Miller, we've got a couple other questions just looking for some clarification, maybe underscoring some points. Someone, Laurie asked, so our clients... Or wanted confirmation or clarification. So our clients aren't eligible for ECM services? And Janet asked how are the hospitals notified if a patient is open to ECM services?

Dr. Laura Miller:

Yeah, let's go back to, I believe it's slide 16 and you're right. Many members who are living in ICF/DD Homes, they already have the services and supports that they need. And ECM would be a duplication of services. However, if a member transitions out of an ICF/DD Home, then they can be assessed for ECM. So I think you're right in the main, they will not be eligible for ECM. This is the slide, I think. It's really this third dot point here. If they transition out of a Home, then they'd be able to be assessed for ECM services.

Dr. Laura Miller:

And then so the second question was how does a hospital know that a member is eligible? At this point, it is... Well one, it is knowing what the eligibility requirements are for ECM and then hospitals can absolutely refer to the plans. So reviewing the ECM populations of focus and then if they discover a member who very well could be in ECM, they can refer into the plan or the hospital case manager could reach out to the plan and say, is this person already in ECM? Right now with our systems, there's not a great way for ECM enrollment to be seen by hospitals. It's really more within the plan and within the ECM delivery system. But ultimately when the Population Health Management service is up and running, then that eligibility and/or enrollment status would be visible. But that is a while off. So I think a lot of it is picking up the phone and calling your plan partner and saying, "Hey, I'm here with Mrs. Jones, who are her people and what programs is she in?"

Kristal Vardaman:

Great. Thank you, Dr. Miller. I think we're going to end this Q&A session. We've got another segment coming up. We'll move on to the next segment and then we will again kick off with questions related to Community Supports, the next section, and try to reserve a few questions for some of the other topics that have come up in the chat. So we'll hope to get there. So now we'll transition. I'll turn it over to Noelle Simonick and Tyler Brennan from MCQMD to talk about Community Supports.

Noelle Simonick:

Thank you so much, Kristal. As Kristal just said, we're going to provide an overview now of Community Supports for Medi-Cal members. Next slide please. Thank you. So here we are. What are Community Supports? Community Supports are services or settings that MCPs can offer as substitutes for utilization of other services or settings such as hospitals, SNF admissions, discharge delays, or emergency department use. MCPs are strongly encouraged but not required to provide these services to eligible members. Community Supports are designed as cost-effective alternatives to transitional medical services or settings and aim to address social drivers of health, the factors in people's lives that influence their health. A key goal of Community Supports is to allow members to obtain care in the least restrictive setting possible and to keep them in their community as medically appropriate. Different MCPs will offer different combinations of Community Supports, and while MCPs must follow DHCS standard community support service definitions, MCPs may decide when it is medically appropriate to utilize Community Supports.

Noelle Simonick:

Community Supports are not restricted to Enhanced Care Management populations of focus and should be made available to all members who meet eligibility criteria for a specific community support. Next slide please. MCPs are strongly encouraged to offer one or more of the Community Supports you see listed here. More details about the pre-approved DHCS Community Supports can be found in the Community Supports Policy Guide linked at the bottom of this slide. MCPs must consider requests for Community

Supports from members and on behalf of members from their families, guardians, and caregivers, ECM providers, Community Supports providers, other providers and CBOs. I'm going to pass it now to my colleague, Tyler Brennan to take the next slide.

Tyler Brennan:

H, thanks so much Noelle. All right, and Community Supports for members specifically in the Long-Term Care populations of focus. So, while the entire menu of Community Supports may be applicable to members in the Long-Term Care population of focus, every member does have different needs and functional limitations. And so the services they're eligible for will vary. Several of the Community Supports that the Department believes will benefit members in the Long-Term Care populations of focus most include, but are not limited to, those that you see here on screen. So, we've called out Medically Tailored Meals, day habilitation programs, environmental accessibility adaptations or home modifications, respite services, as well as personal care and homemaker services. Detailed descriptions for these services and what's included in each can be found in the Community Supports Policy Guide that we have linked on our website. Next slide please. We want to talk a little bit about how members access Community Supports, and there are a number of ways that members can access these services.

Tyler Brennan:

So first, members who qualify may be contacted directly by their health plan and/or a Community Supports provider that they work with. Plans are responsible for regularly identifying members who may benefit from receiving Community Supports and who meet eligibility criteria for the program. Once a member is identified, usually through data, the health plan and/or assigned Community Supports provider will contact them to discuss Community Supports and setting them up. Second, a health and social services provider, including an ECM or Community Supports provider, may submit a referral to the plan. So if a member hasn't yet been contacted by their MCP as eligible for any one of the 14 services, but they do appear to meet the requirements to the provider, that provider can submit a referral to the member’s health plan.

Tyler Brennan:

And the health plan is then required to have a referral process that is available for all providers. You don’t necessarily need to be a clinician to refer someone in for a Community Supports consideration. Finally, members may self-referral or ask for more information to see if they qualify, and that includes family members. So, a member or the member's family can contact their managed care health plan to see if they qualify and are eligible to receive Community Supports. Members can contact their health plan by calling the number on the back of their insurance card.

Tyler Brennan:

And I think going to the next slide, I believe, yeah, so that's moving on to transportation benefits, but we'd like to open up the floor if there are any questions about Community Supports, noting there's a ton of information available on our website, which we'll make sure we link to here in the chat for you.

Kristal Vardaman:

Let's see, are there any questions related to Community Supports? Otherwise, maybe we can just go through, looking to the chat. Oh, one question here: Will DHCS in coming years mandate all 14 Community Supports statewide for all managed care plans?

Tyler Brennan:

So, at this time we're not releasing any information about future plans in terms of the Community Supports becoming available statewide for managed care plans. I believe there are efforts underway towards standardizing the benefits on the statewide level and sort of ensuring parity across counties. So that is where our current focus is. But DHCS will absolutely relay more information as it becomes available about the possible incorporation of these services under the state plan.

Kristal Vardaman:

Great. Thank you, Tyler. I don't see any questions about Community Supports yet, so why don't we go through transportation benefits and then we'll open up again for questions. Hi, Noelle and Tyler, I think you were going to cover the transportation benefits next and then we'll open it up again for Q&A for that section.

Tyler Brennan:

Oh, I actually don't believe the transportation benefits was us, at least it's not Community Supports-related, so we weren't prepared to speak to these.

Kristal Vardaman:

Sure, okay. Well, I'll go ahead and read through them then. No problem. Next slide please. So in terms of transportation benefits, there's two types of transportation that the plans must provide: Non-Emergency Medical Transportation, and Non-Medical Transportation. So NEMT, Non-Emergency Medical Transportation, is provided by ambulance, wheelchair van, or a litter van for members who cannot use public or private transportation to get to and from covered Medi-Cal services and who need assistance to ambulate. NEMT is available when medical or physical conditions do not allow for travel. And these services must be prescribed by a healthcare provider. NMT, Non-Medical Transportation, includes private or public transportation to and from covered Medi-Cal services for eligible members. For NMT, members will need to attest to the provider verbally or in writing that they have an unmet transportation need and all other currently available resources have been reasonably exhausted. Next slide please.

Kristal Vardaman:

For transportation benefits again here, there's some best practices that providers should understand ahead of the Carve-In for transportation. Providers should work with Medi-Cal MCPs to understand the transportation request process. In some cases, prior authorizations may be required for NEMT. MCPs may contract with various transportation vendors and should have policies and procedures in place to ensure timely access to transportation services and that transportation options meet members'

needs. MCP and Subacute Care Facilities or ICF/DD Homes will need to coordinate to provide transportation services.

Kristal Vardaman:

So, for example, MCPs and Subacute Care facilities should communicate which members may require transport needs for dialysis services outside the facility. And additionally, while MCPs are responsible for NEMT and NMT, ICF/DD Homes will continue to be responsible for transportation to and from day programs. So, with that, we will go back to Q&A. So, we'll have another Q&A period to answer any questions about transportation benefit or if any other questions came up on Community Supports, we can raise those as well. And then we'll also try to open it up for some of the questions that have come in on some other topics. So are there any, I'm looking through the chat, a few minutes to bring those up.

Kristal Vardaman:

And regarding the slides, the PowerPoint presentation will be available on the DHCS Carve-In website after some remediation and whatnot. So it should be available next week or so. Let's see, in terms of questions, we had a question about, I'm not sure who from. Oh, someone has, there's a couple questions that have come up. One request about DHCS updating the Physician Certification Statement form for NEMT regarding non-physician signature for certification. I don’t know if there’s anyone on who can answer that or respond to that, but Susan, I did see that came up in the chat.

Bambi Cisneros:

Susan, if you don’t mind saying what changes you were expecting to see in that form, I think that would be helpful because I’m not aware that there are going to be changes that are being made, but it sounds like there’s something there. So if you can give us a little bit more, that would be good.

Kristal Vardaman:

And Susan, I see your hand’s up, so the team will unmute you and you can add some clarification there. You should be open, your line should be open now.

Susan LaPadula:

Good morning Bambi and Kristal, thank you for this opportunity. It's my understanding, Bambi, that the plans would also like to have the form updated because specifically the form reads "Physician Certification Signature”, but actually a non-physician might be the coordinator for that transportation. But I'm sure the plans will give you more feedback.

Bambi Cisneros:

Okay, got it. So the Physician Certification Form is required for NEMT, which is like ambulance for non-ambulatory members. And so the reason why a physician signature is needed is because there needs to be a demonstrated kind of medical necessity for that. Because otherwise NMT, which is like car, taxi, public transportation can be used.

So there's actually a reason why it needs to be a physician signature. Also, the other reason is that we want to ensure and protect members so that they get the right mode of transportation. So for example, some plans do use transportation brokers and we wouldn't want someone who's a non-clinician changing the needs. So if a member really needed to be in an ambulance, we wouldn't want someone one without clinical judgment to have them use a lesser mode of transportation. So that's the reason why it was designed that way. But-

Susan LaPadula:

I'm in agreement with you. Perhaps it's a little bit beyond my expertise and the transportation experts at the plan, maybe a director or manager can give you that specific feedback they're looking for. It was taught this week at one of the health plan webinars, so it is an issue, but perhaps it's beyond my scope.

Bambi Cisneros:

Okay, great. No, thank you for the background and context. And of course, if any plans are on the line and they have some further information you would like to share with the Department for consideration, please do send to us and we will take a look.

Susan LaPadula:

Thank you so much, Bambi. Thank you, Kristal.

Kristal Vardaman:

Thank you.

Susan LaPadula:

Happy holidays, everyone.

Kristal Vardaman:

Happy holidays. We've got a couple more questions on transportation and I think then I'll transition into a few other topics that came up before we closed. Questions on transportation. First, Isabel asks, what happens when the transportation's already set up and the service doesn't show up? So who would pay for private transportation?

Bambi Cisneros:

Yeah, so I think what we were talking about on this webinar was all of the various ways that managed care plans can support and help members, transportation being one of them. And so if there was transportation arranged and the transportation provider did not show up, please do work with the managed care plan if it is for a managed care member because they'll make sure that that doesn't happen. Because really important for members to be able to get to their appointments. So please work with your managed care plan if that's what you're experiencing.

Kristal Vardaman:

And Bambi, another question about transportation: How does the ICF/DD go about requesting transportation payment for one of the clients? And again, this from Becky Joseph emphasizing the importance of an assigned case manager to the facility or the clients. And then also just a follow-up question from Becky around if a client's in an ICF/DD, goes out to the hospital in the middle of the night, but 911 is not necessary and they transport the resident themselves, the Home does, will the facility be able to get paid for that service?

Bambi Cisneros:

Sure, yeah. Becky, in addition to having an LTSS Liaison, plans also have transportation liaisons. And so their role is to really work with providers and members in getting that transportation needed, whether it's reimbursement or actual transportation. So I can offline with you and share that list. But otherwise I would recommend working with the managed care plans. Because they do have staffing to be able to provide these supportive services.

Kristal Vardaman:

Thanks, Bambi. I don't see any other questions on transportation, but early in the session today, we had a question in the chat about the pharmacy coverage of people residing in, I believe in ICF/DD Homes. The question was: primary care providers have stated they can't send out prescriptions unless customers have their insurance numbers, insurance cards on hand. How will this pan out after January 1st? Are we ICF/DD providers supposed to shoulder the out-of-pocket costs? So Bambi, maybe some clarity on what's changing or not changing about prescription coverage?

Bambi Cisneros:

Yeah, so the ICF/DD provider shouldn't be shouldering the costs for that. I think that the decision point is really whether that medication is covered through Medi-Cal Rx or if it's... There's a few medications that are covered by the managed care plan, they're typically like the physician administered drugs. I would start with the plan if you are not aware of what that coverage requirement is. But either way, Medi-Cal does cover that.

Kristal Vardaman:

Great. And I see one hand up. I'm going to ask the team to unmute Rick. And Rick, you should be unmuted.

Rick Hodgkins:

Okay. Yes, thank you. Once again, I'm on my iPhone, I can't use my computer on this meeting, but I had a question and then a comment. The questions is, I know what ECM stands for, Enhanced Care Management, but what does CCM stand for? And also what does the H and the N stand for in ICF/DD-H and ICF/DD-N? What does the H and N stand for? And my follow-up comment that when it comes to Medically Tailored Meals as Medically Tailored Meals, as somebody mentioned, just because somebody has diabetes doesn't necessarily mean that they have to have a Medically Tailored Meal.

They could also be at risk for hypoglycemia and the person could have diabetes for other reasons that are not related to lifestyle. So we need to be very careful. Thank you.

Dr. Laura Miller:

So I hope somebody was taking notes on the multiple parts. I'm certainly glad to take the ECM, CCM definition pieces, Rick. So ECM, as we said-

Rick Hodgkins:

Thank you so much.

Dr. Laura Miller:

Sure. Enhanced Care Management. So, a very tight in-person relationship between a care manager and a member. Complex Care Management, or CCM, is often done by somebody who's an employee of the plan, reaching out to members with complex needs that are primarily medical. Sometimes it's chronic disease management, et cetera. People going through challenging times, perhaps post-surgically, things along those lines. As well as rising risk, people who have multiple chronic problems that if we don't get a handle on them could culminate in clinical challenges further on down the road. So I think of CCM as a lighter touch. It's primarily telephonic, but very much helping people navigate our systems and get the care they need for illnesses. So those are the points that… let's see, that was ECM and CCM. What were the other points?

Rick Hodgkins:

About what does the H and N stand for in ICF/DD-H and ICF/DD-N? And also my comment was about Medically Tailored Meals.

Dr. Laura Miller:

Oh, right.

Rick Hodkins:

Yeah. Because just because somebody has type two diabetes, for example, yes, dietary and lifestyle modifications should be a first line of defense. But if it turns out the person has diabetes because they have panhypopituitarism, then you need to look at medication management because that person's also at risk for hypoglycemia. And also one diet plan, whether it be the keto diet, Mediterranean diet, whatever, is not going to work for everybody. So, thank you.

Dr. Laura Miller:

Got it. So I'm going to phone a friend for the H and the N because I think N is "nursing" and H is "habilitative". But other folks know more than me on that one.

Kristal Vardaman:

Yes, Laura, you're correct on that.

Dr. Laura Miller:

Awesome. I can learn! And then with regards to the Medically Tailored Meals, that's a Community Support. From what I know of the Medically Tailored Meals, it's really not a one size fits all, check the box, you're diabetic and you get X. There's discussion and outreach of individual needs there. So I totally hear you, Rick, about the different causes for various different states, but I believe that there is individual tailoring there.

Bambi Cisneros:

Yeah, there is. There's certain eligibility criteria. So Rick, you were right. So usually it's tied to someone having a chronic condition and other things. And so, the various Community Supports that the team talked about today does have certain criteria that members must meet to be eligible for those services.

Dr. Laura Miller:

Thank you, Bambi.

Kristal Vardaman:

Okay. Looking through the chat, I think the team has been responding to some questions that have come up recently. Let's see. I will go through quickly. One question. What happens when the managed care plan doctor recommends a different order than the ER doctor? How do case managers handle this?

Dr. Laura Miller:

That is going to be probably on a case-by-case basis. Often times, having been a managed care plan doctor in my past, the decisions is made looking at medical necessity, looking at formularies, and then I think the case manager is actually in the role of a translator and a go-between, making sure that whatever is ordered makes the most sense for the patient.

Kristal Vardaman:

Great, thank you. Well, I think with that, we're going to close the question session right now because we've got just a few minutes left. So we'll go on to next steps, and, next slide please. So thank you to everyone who joined us today for your thoughtful questions and your participation. In the last few minutes, we're going to share some resources for you to learn more about the information presented today and then on the ICF/DD and Subacute Care facility Carve-Ins. Next slide please. This slide has some key resources on information provided today, specifically Population Health Management, Enhanced Care Management, and Community Supports. Next slide please.

Kristal Vardaman:

And this slide links to additional resources. Again, this will be available when the slides are posted. On the Subacute Care Facility Carve-In, there are some updates in terms of policy guidance and information on upcoming webinars. That'll be posted on this page.

Next slide, please. DHCS also has a series of resources available on the ICF/DD Carve-In webpage, including the ICF/DD Carve-In APL, All Plan Letter, Model Contract Language, Frequently Asked Questions, and a Billing and Invoicing Guide. We'd encourage you to check out the ICF/DD Member Information webpage as well, which will be linked from that main page. And there you can find copies of the member notices, the notice of additional information and a Plain Language Fact Sheet.

Kristal Vardaman:

And again, as a reminder, today's slides will be posted to the ICF/DD and Subacute Care Carve-In webpages in the coming days as soon as the recording is processed. And with that, we'd like to thank you all again for your time and we look forward to your continued engagement on the LTC Carve-In. If you have any additional questions that were not addressed during this webinar, we'd ask that you email LTCtransition@dhcs.ca.gov. And with that, happy holidays and we look forward to seeing you all in 2024. Thank you.