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SPEAKERS

Kristin Mendoza-Nguyen
Bambi Cisneros
Dana Durham
Jim Knight

Kristin Mendoza-Nguyen:

Happy Friday and good afternoon everybody. I'm giving folks a minute to join from the waiting room. Thank you for joining today's session, the CalAIM Intermediate Care Facility for the Developmentally Disabled Carve-In Office Hours. This session is part of an educational webinar series about the ICF/DD Carve-In. A recording of today's session, the slides, and meeting materials will be available on the DHCS ICF/DD Long-Term Care Carve-In webpage. You can find that link to the webpage in the Zoom chat. Next slide. We'd like to ask you all to take a minute just to add your organization's name to your Zoom name, this will help track any questions that we need to follow up on. You can add your organization by clicking on the participant's icon at the bottom of the window, hovering over your name in the participants list and selecting rename. Next slide.

Kristin Mendoza-Nguyen:

A few things before we begin. This session is being recorded. Participants are in listen-only mode, but they can and will be unmuted during the Q&A discussion as needed. To participate in the Q&A discussion, please do use the raised hand feature and our team will be able to unmute you. We also encourage questions to come in through the chat throughout the presentation and our team will be monitoring them. Next slide. This is today's agenda. We'll start off with a brief overview of the key policy requirements and promising practices. A bulk of the time will be spent as usual for these Office Hours on stakeholder questions, and then we will wrap up with some next steps. And so with that, I will turn it over to Bambi Cisneros, Assistant Deputy Director of the Health Care Delivery Systems to kick us off for today.

Bambi Cisneros:

Great, thank you. Thank you so much Kristin, and welcome everyone, good afternoon. Thank you for joining us for this Office Hours. And we can go to the next slide please. Before diving into some of the key policies and some Q&A, wanted to just give a brief orientation, I think you may have seen the slide before if you've joined us on previous sessions, but just wanted to share that the ICF/DD Homes transition to managed care that was effective January 1, 2024, was impacted about 4,000 members that were identified to transition to a managed care plan from Fee-for-Service. And so about 95 percent of these members transitioned on January 1st. And again, the goal and intent for doing this long-term care benefit statewide was just to ensure that the member experience would stay the same regardless of which county the member moved. So this used to be a county by county coverage and now the ICF/DD Home coverage is now statewide across all of our Medi-Cal managed care plans that impacts the three ICF/DD Homes that you see listed here, so the ICF/DD, ICF/DD-H for habilitative and ICF/DD-N for nursing homes.

Bambi Cisneros:

And then I previously mentioned that about 95 percent of these members transitioned to a managed care plan on January 1st. So you may wonder why not 100 percent? And so there are some reasons that members may not have transitioned on January 1st, as

you may have expected. And some of those reasons include if there was a change in Medi-Cal eligibility, if there were a county or address mismatch changes, in which case the member would need to go to the county eligibility office to resolve, or that if members were to choose a plan, a managed care plan after the cutoff date on their Choice Form, that the Department is now having to place them into their selected plan after that cutoff date. So just wanted to make sure you had this background information on the members that have transitioned to managed care effective January 1st, 2024. And with that, I will go to the next slide please. Okay, so touching on... Oh, a Leave of Absence and Bed Holds, so I will turn this over to Dana Durham in MCQMD for the next slide.

Dana Durham:

Thanks, Bambi. You're probably aware that managed care plans must include as a covered benefit, any Leave of Absences or LOAs as they're traditionally referred to or Bed Holds that an ICF/DD Home provides in compliance with state regulations on Leave of Absences and Bed Holds. And so, the managed care plan must authorize up to seven days per hospitalization for a Bed Hold and they must authorize up to 73 calendar days for a Leave of Absence. And managed care plans must have Utilization Management or UM policies and procedures in place to support the receipt review and approval or denial of authorizations for Bed Holds. Now, previously some of the managed care plans may have required prior authorizations for Bed Holds and they still can require those, but when it comes to Leave of Absences, the managed care plan must not be more stringent than the requirements in the Medi-Cal Provider Manual, which really are highlighted here on this slide.

Dana Durham:

And first, readmission authorizations are not necessary for a member returning from Leave of Absence if there's a valid authorization covering the return date. Second, a member's record maintained in an ICF/DD must show the address of the intended leave destination and inclusive dates of leave. This means that the managed care plan may not require authorizations for Leave of Absences except for an overnight Leave of Absence for summer camp. Finally, the only time documentation is needed for a Leave of Absence is when a physician's signature is required for that summer camp. And next slide please.

Dana Durham:

I do want to go over the claim submission process and talk about billing and payment. So, the managed care plans must have a process for ICF/DD Homes to submit claims and receive payments electronically, as well as an invoicing process for ICF/DD Homes unable to submit electronic claims. While the claims submission and payment processes will vary by plan, this process flow provides an overview of the steps involved. So you'll see that someone should prepare to submit the claim, submit the claim, be able to track the status of the claim, and then receive an authorization or denial of the claim. And the next few slides will provide a closer look at each step as well as offer promising practices for ICF/DD Homes and plans to support prompt claim submissions and payments. And I'll have you go to the next slide.

Dana Durham:

Now, the first step of the process is preparing for claim submission. As you get ready to submit a claim if you're a provider, it's important to know where you may run into challenges that can lead to a denial of a claim. So that can include things such as submitting claims to the wrong managed care plan or wrong payer, missing information or having incorrect information in the claim or submitting the claim twice or duplicative claims. Now, it's also important to note that plans are not required to align billing codes with Medi-Cal Fee-for-Service, however, the plans will and are required to share the codes that they use with their providers. To help providers prepare for claim submissions, plan must have processes to receive electronic claims and they must provide training to ICF/DD Homes on their billing protocols. So plans and providers should work together to ensure that billing codes and submission processes are understood.

Dana Durham:

Now, there are few steps that ICF/DD Home providers can take to prepare for submissions as well. They include checking the payer listed in the Medi-Cal's eligibility record and AEVS or the Automated Eligibility Verification Systems to make sure you're billing the right person, validating plans, billing codes to ensure the appropriate codes are used and verifying the dates of service that they align with the authorization effective dates. Next slide please.

Dana Durham:

When you talk about claim submission processing in general to streamline claim submissions, managed care plans may use various third-party vendors or clearinghouses with different processes for claim submission. When the managed care plan uses clearinghouses, they may not have immediate visibility into the status of the provider's claim submission, but we encourage ICF/DD Home providers to check, which if there are any clearinghouses, managed care plans may use for electronic claim submissions. We do know the ICF/DD Homes are working to get accustomed to plans billing processes, and so for that reason, a very good practice is to make sure that you have continued conversations so that you understand the billing protocols to assist in claims processing. Next slide, please.

Dana Durham:

Once a claim is submitted, it's very important for providers to track the status of their submission to verify whether or not they've been accepted or rejected. So, in some cases, the claims may pass through the clearinghouse but be denied by the managed care plan. So, to help the provider monitor their claims submissions, managed care plans are encouraged to allow providers to access electronic billing systems or provider portals regardless of the contracting status. If for some reason the portal's not available, managed care plans are expected to provide technical assistance and support to enable the provider can track their claims and billing. Next slide.

Dana Durham:

After your claim is submitted, the claim will be approved or denied by the plan. If a claim is denied the managed care plan will provide the denial reasons and the provider will need to address the denial reasons or codes and resubmit the claim. Providers will receive remittance advice which provides details on the claims that are paid or denied. Managed care plans are required to include all data elements listed in the Medi-Cal Provider Manual and the remittance advice they send. This includes details like the date of service, the accommodation codes and rates. And so to support prompt payment of approved claims, ICF/DD Homes and managed care plans should work closely to set up ICF/DD Homes for EFTs or electronic funds transfer if that is requested by the Homes. ICF/DD Homes providers should work closely with managed care plan to understand what each managed care plan requires from providers for billing and how providers will be paid. Now depending on how each plan sets up providers, it may have impacts on how that payment is made. So I've gone through a lot, so I think it's time to transition over to Kristin for questions.

Kristin Mendoza-Nguyen:

Great, thank you Dana. We will start with kicking off the Q&A with some pre-submitted questions we received from the registration forms, and then we will open it up for folks on the line. Next slide. So this first question is for Stephanie from our Managed Care Operations Division at DHCS. We have a question on the eligibility record for an ICF/DD Home member who is newly enrolled in Medi-Cal indicates they're covered by Medi-Cal Fee-for-Service, is the ICF/DD Home able to bill Medi-Cal Fee-for-Service?

Stephanie Conde:

Thanks Kristin. Yes, the ICF/DD Home should bill Medi-Cal Fee-for-Service since that is the payer indicated on the member's eligibility portal. Just a little background, when an individual is newly enrolled into Medi-Cal, they are covered by Medi-Cal Fee-for-Service until that member is enrolled into a managed care plan if they are in a managed care plan aid code. Once the member is enrolled into the managed care plan, coverage in that plan goes into effect on the first day of the following month. The ICF/DD Home provider should bill the payer indicated and the member's eligibility record in the AEVS system, so the Automated Eligibility Verification System, which is on our Medi-Cal provider portal, and the link is provided in the slide deck.

Stephanie Conde:

If AEVS does indicate Fee-for-Service, the provider should bill that Medi-Cal Fee-for-Service for service provided for the member on the date that the member had that Fee-for-Service. If AEVS does list a managed care plan, the provider should bill the managed care plan following the plan's billing processes. And just a note, if the member is in Los Angeles County, providers should be checking the prime plan's provider portal as well to see if the member's in a delegated plan.

Kristin Mendoza-Nguyen:

Great, thank you. The second question, next slide is for Jim Knight at DDS, is Regional Center lag funding still available to ICF/DD Home providers?

Jim Knight:

Thanks Kristin. Lag funding or as it says here, it's temporary payment assistance is still available to Regional Centers that there are delays in the Homes getting reimbursed from the plans. As it says here, to get lag funding, the provider has to, number one, enter into an agreement with the Regional Center and then attest to one of the two items there in the list. So when they submit their request for the lag funding to the Regional Center, it's either that the claims have already been submitted to the managed care plan, it's been at least 30 days and they still have not been reimbursed, or if there have been delays or they have not even been able to submit a claim, then lag funding could be available as well. On that, I know that we have been made aware of in some cases, some issues with the issuing of those payments and we are addressing those as they arise.

Jim Knight:

And I'm going to put in the chat if there's any questions or there's concerns either from Homes or Regional Centers regarding any lag funding, you can email us and we can address those. Also, the lag funding, the payment says, have to be repaid no later than 15 days. In probably the next several days, we'll give some further guidance on when that period starts. We know that the lag payments may be going out for certain periods of time, but the reimbursements that you're getting from the plans may not exactly align with that period of the lag payments. So we'll give some details on when that 15-day period starts. Also, just to be aware, currently the Regional Center directive indicates that the lag funding is available through services provided in June. We will be announcing that formally, but we'll let you know now so that you're aware that that time period is going to be extended. So more details to follow there.

Kristin Mendoza-Nguyen:

Great. Thank you, Jim. Okay, and then our third question is for Dana, do ICF/DD Home members receive Continuity of Care for durable medical equipment, DME and medical supplies?

Dana Durham:

Yeah. Thanks for this question. The managed care plans will allow transitioning members to keep their existing durable medical equipment and medical supplies from their current provider under a previous authorization for a minimum of 90 days following enrollment. This must be authorized without a request from the member or authorized rep or provider. Now, after those 90 days, the active treatment authorization remains in effect until the treatment authorization has run its course or until the completion of a new assessment by the managed care plan, whichever of the two is shorter. Now, once that managed care plan reassesses the member's authorization, they may switch to an in-network DME provider. But just be sure you're in conversations with the plans to

make sure they know your needs and introduce them to your DME providers. And with that, I think I'll hand it back over to you Kristin.

Kristin Mendoza-Nguyen:

Great. Thank you, Dana. Next slide. Okay, so we're going to move into some logistics. We've already received a number of questions in the chat that we're tracking. Please continue to send some and we will get to them. You may be asked to unmute yourself if we need clarification, so just a heads-up and our team will unmute you. I'm going to open up the Q&A because I know Rick Hodgkins, you've had your hand up for quite a bit. So the team will go ahead and unmute you and open the line for your questions.

Rick Hodgkins:

Yes. Real briefly, I have up to three different questions. Two of them relate to this topic and one is a general question. The two questions are just relative to this topic and subject at hand are, what does the managed care plan pay for and what does the Regional Center pay for? My guess would be that the Regional Center pays for whatever is in the client consumer members' IPP and I take it that the managed care plan pays for the stay and the rent and the stay for in the ICF/DD Home.

Rick Hodgkins:

And the second question I have as it relates to the subject and topic at hand is, what are the reasons for a client/consumer/member, if you will, being denied admission into an ICF/DD Home? And my third question which is a general question, this is a question which I asked earlier this month, and that is, are clients in ICF/DD Homes all bedridden or do any of them go to activity programs, day programs or to recreational programs or work? Thank you. And if you don't have answers for me during this call, please email me because again, my email address is in the registration form. Thank you.

Dana Durham:

I guess I'll start and then we'll go from there. And I'm sure, Jim, I'd love to have you help. Medi-Cal covered benefits are what is paid for by the managed care plan. And that's a whole list, it would be really hard to go through that, Rick. It's not changing who's paid for, what was previously paid for through our Fee-for-Service Medi-Cal is now being paid for through the managed care plan. And Jim, I'll defer to you on the other questions if you don't mind.

Jim Knight:

For what the Regional Center would pay for would be those other services that are in their individual program plans. So typically that's going to be things like day service, transportation, those are going to be reimbursed by the Regional Center or any of the other typical services that are in that individual program plan that are not covered by Medi-Cal.

Dana Durham:

I think a couple others, Jim, that you might have some insight into, are there reasons that someone would be denied to an ICF/DD Home? And are all individuals bedridden or do they go out and do some of them have jobs? Those were the other two questions.

Jim Knight:

Yeah. For the second part of that, no, not all individuals in an ICF are quote, "Bedridden," a number of folks are receiving services I mentioned outside the Home, whether it be day services, could be employment and the like. And what was the first part of that Dana? I'm sorry.

Dana Durham:

Yeah. Are there reasons that someone would be denied for an ICF/DD Home?

Jim Knight:

Yeah. And so that one I think may be more for DHCS and maybe in general. From what I'm understanding is that it's more if they don't necessarily meet what would be considered the quote, "Level of care or level of need requirements." But as far as more specifics, I'm not sure I'm going to be able to comment on that.

Dana Durham:

And I'd say that's where, I am too, that they would need to meet the level of need to be in an ICF/DD Home. And that's a pretty complicated and a medical determination. So just that would be the reason.

Kristin Mendoza-Nguyen:

Okay, great. Thank you guys. All right, so the next... I'm going to go... The earlier question we received from Danette from Peppermint Ridge, "How do we do a pre-authorization for an emergency hospitalization?" Any thoughts either Dana or Bambi?

Dana Durham:

Can you say that one again? Sorry.

Kristin Mendoza-Nguyen:

The question came from Danette from Peppermint Ridge, "How do we do a pre-authorization for an emergency hospitalization?"

Dana Durham:

There would not be a pre-authorization for an emergency hospitalization. If somebody needs to go to the hospital, take them to the hospital, don't delay. Then once that person is stabilized, they will go through a process of contacting the managed care plan about what the appropriate level is for post-stabilization if they need to stay in a hospital. But you do not get authorization in an emergency situation.

Kristin Mendoza-Nguyen:

All right, thank you. I think this is probably a follow-up for Stephanie Conde. We received a comment from Susan LaPadula related to how delegates are shown in AEVS. You already mentioned this, but can you speak to how providers can determine if their members are enrolled in a delegate plan?

Stephanie Conde:

Hi, Susan. Yeah. In Los Angeles County, they're, as you mentioned, subcontracted plans, so providers can see in AEVS what plan the member's enrolled with at their prime level and then look at the prime plan's provider portal to see if the member is enrolled in the delegated subcontracted plan. As you mentioned, we are working on enhancements to ensure that the AEVS system does represent the delegated plan. So we're working very closely with those plans in Los Angeles County to get AEVS updated. So we have been making progress in working with the plans and meeting with them to get the system updated. But in the interim, like we said, the providers can check the prime plan's portal to ensure that they know what delegated subcontracted plan that member's enrolled in. Thanks, Susan.

Kristin Mendoza-Nguyen:

Great. Thank you Stephanie. The next question is related to contracting. So this came in from Naomi Thompson from Promise Health Plan, "There's some discussion about a Letter of Agreement (LOA) and a contract, could DHCS provide just some information on what the difference is for the Letter of Agreement, what its intent is, and why are plans asking ICF/DD Homes to sign an LOA while working on their Network Provider Agreement?"

Dana Durham:

We want to make sure that you do have a way to work to together the plans and the Homes as you come into contract, because contracting is usually a longer process. So what allows that is a Letter of Agreement often. So want to make sure everyone is comfortable with the contract before it's signed and that you've been able to discuss it. And so in the interim, a Letter of Agreement or agreement between the plan and the Home about how you operate together, it includes various things like some of the details about how you will operate together. It can include payment, but it is not a full contract. And we ask people to do those as they're coming into contract with each other. Hope I answered your question.

Kristin Mendoza-Nguyen:

Okay. And a question for billing, from a Trista Milan, "Who do we bill for claims dated early last year? Do we bill Medi-Cal Fee-for-Service or the MCP?"

Dana Durham:

Yeah. You should bill whoever is, and Stephanie you feel free to answer this, I was just going to say whoever is responsible for the individual in AEVS at the time that the service was given. So if they transitioned on January 1st, anything last year would be

billed to Fee-for-Service, but if they transition, let's say March 1st, also everything in January and February would be billed to Fee-for-Service. Stephanie, sorry, I didn't see you coming off or I wouldn't have...

Stephanie Conde:

You got it. It's perfectly said. And AEVS does, you can put the enrollment date into AEVS and you can see by month a delivery system that member was enrolled in. Thanks Dana.

Kristin Mendoza-Nguyen:

Thank you both. Question from Karoline Lee from Golden State Care Center, "Is it possible that an MCP would transfer the patient's enrollment to another MCP? I had a handful of residents switch from Molina to Health Net without warning and without requesting Molina to do so."

Stephanie Conde:

Hi. And for that one, if you can let me know your email and we can look into the member experience because it's definitely scenario based. And so I don't want to respond without looking a little bit more into the detail. If you could please post your email and then I'll send you a secure email and we can look into those members' CINs (Client Index Number). Thank you.

Kristin Mendoza-Nguyen:

And then a question from Jaclyn Hagon, "Can you clarify what is expected to be kept on file in regards to this requirement in the APL? MCPs must ensure contracted ICF/DD Home providers receive a preapproval or assessment of suitability from CDPH prior to the execution of a contract for ICF/DD Home providers undergoing a change of ownership."

Dana Durham:

Jaclyn, I'm going to phone a friend and see if Adrienne is on and can answer this question. If not, we'll follow up with you in writing, but it's the process in which ICF/DD providers go through for change of ownership. But we'll answer more in detail in writing unless you know Bambi.

Bambi Cisneros:

No, I think I was just going to say our intent in developing this policy was to really try and preserve what existed before. And so we understand that ICF/DD Homes have various submission requirements, and this one piece to Department of Public Health is an existing process. So if there is actually an ICF/DD Home who has recently undergone this and can provide more details as to what this looks like to help other providers, I think that would be helpful.

Kristin Mendoza-Nguyen:

The next question is from Steve Loflin from Higher Grounds Homes Incorporated, "If we have the Letter of Agreement, how long do we have to complete the contracting? We have heard anywhere between six months to a year."

Dana Durham:

Yeah. Appreciate that question too. There's no specific time for that really—

Adrienne McGreevy:

Can I actually interrupt here?

Dana Durham:

Yeah, go ahead Adrienne.

Adrienne McGreevy:

I'm sorry. Because I think what is getting confused is the requirements for network requirements versus Continuity of Care. So of course we've said, "Yes, there's Continuity of Care for 12 months. And so you have up to 12 months to get a contract with an agency." But we do have network readiness requirements that are due at June 30th, 2024, so six months from the beginning of the year. But in that case, you're only required to submit the minimum number of contracts to fulfill network readiness in that instance. So not all contracts are due June 30th, but you do have to meet network readiness requirements by then. I hope that answers your question.

Kristin Mendoza-Nguyen:

Great. Thank you, Adrienne. The next question, this is a plan specific question for IEHP, this came from Stacy Sullivan of Mountain Shadows, "Why do some providers who have not signed a contract with IEHP have full access to the portal while others don't?" If there's any folks who want to respond, you can feel free to raise your hand, the team can unmute you.

Dana Durham:

Do we have somebody on from IEHP?

Kristin Mendoza-Nguyen:

I see Ben, he just responded in the chat. Oh, there we go.

Dana Durham:

Great. And Ben, we can unmute you.

Ben Jauregui:

Good afternoon. Can you hear me?

Kristin Mendoza-Nguyen:

Yes.

Ben Jauregui:

Hi Stacy, this is Ben, the LTSS Liaison. I'm happy to help you Stacy, if you'll contact me after this meeting. I put my email in the chat, feel free to reach out to me or call me on my cell phone. I'm happy to help. I don't know the specifics of your situation, so I wouldn't be able to give you a quick response here, but I'm happy to look into it and give you an answer hopefully today if we can connect afterwards.

Kristin Mendoza-Nguyen:

Thank you, Ben. Stacy, we'll go ahead and unmute you.

Stacy Sullivan:

Hi Ben. This is a question that's coming up from several providers, so it's not just a Mountain Shadows issue and we're getting inconsistent messaging back, some providers have full access without a contract, others don't. There's just been some real inconsistency and I was hoping to get an understanding from you that would clarify for all the members that have that question. So it's not just a specific Mountain Shadows question.

Kristin Mendoza-Nguyen:

Thank you Stacy.

Dana Durham:

Ben, I'm wondering if there's reasons that people may not have access to that portal and just if you could go over some generalizations.

Ben Jauregui:

Sure. It could be, it's possible. So every provider has to be set up in our system in order to have access. And so sometimes there's an issue with the TIN (Tax Identification Number), the EIN (Employer Identification Number) or the NPI (National Provider Identifier). There's a lot of work behind the scenes that has to be done in order to grant access and the level of access. So it's just a matter of getting the information that we need in order to grant that access, and then internally, of course, because of we're trying to protect health information, it's quite a process actually to grant access to folks. And so it does take a little bit to provide that access.

Ben Jauregui:

The only thing I can think of to generalize it, is that it's all about setting up that access, having our team set up the access in the back end. And I wouldn't be able to speak up with a technical process, but I know that our team is working diligently to try to provide as much access as we can to everybody. It's just a matter of everybody has unique circumstances I believe, or unique situations where we have to figure out how to grant

them access. But I'm happy to speak to anybody who has those concerns directly and we'll definitely connect and see what we can do to help.

Kristin Mendoza-Nguyen:

Stacy, you should be able... Oh, there you go.

Stacy Sullivan:

Yeah. Ben, I appreciate those comments. I do believe that there has been a lot of reach out from providers and we're getting different messaging, so that's why we want to continue to bring this issue to your plan so that we all have access to the portal. And I can appreciate that you need information, however, I believe that the providers have provided you with the information, and I can speak for ourselves, our organization. So I'll speak to you again offline, but it is becoming a big issue for providers and for other plans that do not access portal, it's a huge issue for us.

Kristin Mendoza-Nguyen:

Okay. Thank you Stacy, and thank you Ben. There is another plan-specific question. This is for Kaiser, so if there's any Kaiser representatives that could help respond, but a question from Shelly Dawson, "We have yet to receive any reimbursement for services from Kaiser this year. Any idea of timeline of when Kaiser will be on track to reimburse services?" Do we have any Kaiser folks that might be able to help assist? Okay. Not seeing any hands. Oh, Angelica, we'll unmute you.

Angelica Bender:

Hi, Angelica Bender from Kaiser. Thanks for the question. I will be happy to put my email in the chat if we can connect offline and we can look into that for you.

Kristin Mendoza-Nguyen:

Great, thank you. And then there's a similar question for Anthem Blue Cross. So if there's a rep from Anthem Blue Cross that could also assist, that would be greatly appreciated as well. Okay. There was a follow-up to the earlier question from Trista Milan from billing last year, "When we billed Medi-Cal, we were denied because our clients were enrolled in the MCP in December. However, the MCP is also denying us for last year's claims. Is there a way to bill that would get the claims approved?"

Stephanie Conde:

Yep. I'll jump in. Same thing. If you can send me an email, the members, again, scenario-based situations, so we can look into it, but we'll be able to work with you. If you could just send me or put your email in the chat and I'll send you a secure email. Thank you.

Kristin Mendoza-Nguyen:

Thank you. Plan-specific question for Anthem from Steve Loflin, Higher Ground, "Changing our taxonomy code has been requested by Anthem, is this common since

Medi-Cal has been paying us since 2011 under the same code?" Any Anthem representatives that might be on the line. Okay. We're not seeing... I'm keeping an eye on the chat to see if there's other questions. We'll give folks a couple of minutes, but we don't see any other questions. Anyone who wants to raise a hand if you have any last things? Okay. Diane VanMaren. I'll unmute you.

Diane VanMaren:

Thank you. It seems, and I know you noted it in your slide deck here today, but there seems to be continual confusion regarding what codes to use for billing. Because as this person noted, people are used to using Medi-Cal Fee-for-Service codes, and then we found out that each managed care plan can use their own set of codes. And it hasn't been clear from each managed care plan because remember, ICF/DD Homes are oftentimes using at least two, oftentimes four if not more managed care plans because of their service area and whom they serve and all the rest. So there's a lot of confusion over which codes one is supposed to use. So if there could please be a search process that DHCS could ask the managed care plans to use so people know what the correct codes are that they're supposed to enter into the billing system.

Diane VanMaren:

The other piece also pertains to continual issues and getting access, which has been going on for months now regarding the provider portal. We just heard a conversation with IEHP, which seems to be particularly problematic for many ICF/DD Homes. So again, if those two critical areas can please be clarified, then our Homes would be able to get billing more consistently and we could finally move through this transition much more cleanly. So if there's a way we can focus on those two areas, I think that would be quite helpful. Thank you.

Bambi Cisneros:

Yeah. Thank you for the comments, Diane. I think the two issues that you highlighted pertaining to billing codes and the provider portal really ultimately has to do with communications from the plans. And so our understanding and in conversations with the plans is that they have shared out this information and so we did ask plans to provide us where that is posted and where it's shared, and so we will gather that information from the plans. But we have asked that they share that with their providers as well. I think understanding that there's large plans, many providers, and so I think the information should be trickling in if the providers haven't received it already. But thanks for the comment and understood, it's important.

Kristin Mendoza-Nguyen:

Any other last questions before we wrap up? Oh, there's a Godwin in the chat if the team could look to unmute. I see a hand in the chat.

Godwin Aka:

Hey, just to piggyback off of what Diane was asking. So similarly with communication, and maybe I missed this point, but we are having clients automatically disenrolled from

the portal, sorry not from the portal, on the enrollment site where we go to check their eligibility. And this has happened with me and somebody else, this particularly were two Health Net clients that I actually have evidence of enrolling and I shared with Diane. And the issue is when they get disenrolled and we look on the enrollment sites, it tells us to call a number. That number doesn't know what we're talking about and directs us to DHCS, DHCS so far I've been directed back to the county Medi-Cal. And in Sacramento County, the Medi-Cal number does not have a voice message, so you just call and call and it tells you to call back later. And it's becoming a frustrating point because for the past two weeks I haven't been able to talk to anybody about that.

Godwin Aka:

On top of that with Health Net, and I've shared this with them, trying to communicate regarding... Just trying to get feedback on submissions that we were able to submit to the clients that are still enrolled, I've sent emails and I've been told that they will let me know if my, because again, we don't have access to the portal, let me know if my claim was accepted. And I sent this email on the sixth, a supervisor told whoever was covering for my rep that I should wait for the rep to come back from vacation. And that's just not appropriate. It doesn't make any sense. There is truly no... It's a frustrating process because we're trying to be proactive to get information. But I'll use an example of Central California Alliance, if a claim is submitted, they're really, really great with us because even if we don't have access to communication, we have a number to call to get feedback and actually they're really honestly supportive in trying to solve our problems. So I guess this is more of a complaints than a question.

Dana Durham:

I heard you. Really thank you for raising your concern. I'll put my email in the chat and if you could let me know if you are directed or if you're told to wait for someone that's inappropriate and would love to follow up on that because that's not okay, but hear your other concerns as well.

Kristin Mendoza-Nguyen:

Okay. I guess a follow-up question from Grace Kano regarding Molina, maybe Dana if you can give any update, "But is there any other information about Molina reimbursing facilities or providers for any fees incurred by using their V-card?"

Dana Durham:

There was an email sent out by Molina regarding this, so if you put your information in your email in the chat, we will follow up with you and have Molina follow up with you regarding that.

Kristin Mendoza-Nguyen:

Question from Steve Loflin from Higher Ground Homes, "We have been requested to submit our surveys and POCs by MCPs. Is this a requirement? I have not seen this as a requirement for contracting."

Bambi Cisneros:

That sounds to be some of the items that would've been covered by the attestation for credentialing. If others are hearing differently, please chime in. But Steve, there's a streamline credentialing process where providers would need to submit an attestation form for certain documentation that's valid and then the plan would be accepting that in lieu of the documentation. And so that's all outlined in our All Plan Letter in terms of what would be covered in that attestation form. And we'll drop the link in the chat.

Kristin Mendoza-Nguyen:

And then Steve, feel free to raise your hand if you want to add any clarification on the surveys or POCs. Question from Danette McCarns, "Is there any chance of temporary relief from QA fees until we have resumed a regular revenue stream?"

Dana Durham:

I'd encourage you to have a conversation with your managed care plan to talk to them about that.

Kristin Mendoza-Nguyen:

Thanks Dana. A question from Becky Joseph on LOAs, "If we are going to follow Medi-Cal Provider Manual guidelines regarding LOAs, do we still need to submit the dates of LOA, where the consumer went and the return dates?"

Dana Durham:

Those will be part of, when you send in your billing because you bill with different codes for LOAs, so just to note that that's the way that that will be tracked going forward. You will not need to submit them in advance, but some of the plans are working on aligning with that, so just be patient if you're asked for that and just let them point them to our guidance. But happy to follow up if you're getting someone specific, Becky.

Kristin Mendoza-Nguyen:

Great. Some resources are shared in the chat. Thank you, David at Health Net. Any other questions? Okay, not seeing anything else. I will proceed with closing us up, so next slide. Again, these are just the resources that we have available to the webpage. The next Office Hour is taking place next month, April 25th at 10:30 AM. This will be the final Office Hour in the series for the ICF/DD Carve-In. All the materials from today and the past ones are going to be available on the webpage. And then the item that is also going to be working to be updated is the FAQs based off of some questions from today. So when that gets updated, you will see that on the webpage. Next page or next slide.

Kristin Mendoza-Nguyen:

As always, if you have additional questions that were not addressed during this webinar Office Hour, please email us. Thank you for today's thoughtful discussion and the questions. We appreciate all the engagement in the chat from all the providers as well as the plans. I hope you have a good rest of Friday and enjoy the weekend.