CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

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

TITLE: CalAIM Intermediate Care Facility for Developmentally Disabled (ICF/DD) Carve-In Office Hour

DATE: Friday, December 1, 2023, 1:00PM to 2:00PM

NUMBER OF SPEAKERS: 5

FILE DURATION: 57 minutes

SPEAKERS

Kristal Vardaman
Dana Durham
Michael Jordan
Kathy Nichols
Stephanie Conde

Kristal Vardaman:

We'll go ahead and get started. Good afternoon everyone. My name is Kristal Vardaman and I'd like to thank you for joining today's webinar, CalAIM Intermediate Care Facility for the Developmentally Disabled Carve-In Office Hours. This session is part of an educational webinar series about the Carve-In. A recording of today's session, the PowerPoint slides and meeting materials will be available on the DHCS ICF/DD Carve-In webpage and you'll be able to find a link to that in the Zoom chat. Next slide please.

Kristal Vardaman:

Before we get started with the presentation, we'd like to take care of some little bit of housekeeping. So, we will start with how to add your organization to your Zoom name. So, we'd ask that you take a moment now to add your organization's name to your Zoom name so that it appears with your name, and that'll help us track any questions that we need to follow up on. To do this, go ahead and click on the Participants icon at the bottom of the window, and then hover over your name in the Participants list at the right side of the Zoom window and select "Rename". You can then enter your name and add your organization as you would like it to appear. Next slide please.

Kristal Vardaman:

A few other notes in terms of housekeeping before we start again, the session is being recorded. The recording and the slides will be posted to the DHCS ICF/DD Carve-In webpage. Participants are currently in listen only mode, but can be unmuted during the Q&A discussion. And to participate in that discussion, please use the raise hand feature and our team will unmute you. You can also use the chat feature to submit any questions, so feel free to type any questions into the chat during the presentation, and our team will be monitoring them. We're going to try to answer some questions in the chat as we go along. And then later in the session, live, we will have an opportunity to answer those questions as we go along. Next slide please.

Kristal Vardaman:

And so next we've got the agenda for today's webinar. We're going to start off with a brief overview of the key Carve-In policy requirements and member outreach efforts. And following that we'll have an opportunity to discuss stakeholder questions. We'll kick off the Q&A period by addressing questions that we've received on recent webinars, including the most recent Billing and Payment webinar, as well as those submitted in advance of today's session, before we open up for questions from attendees. And then finally, we'll wrap up with some next steps. So now I'm going to turn it over to Dana Durham from the Managed Care Quality and Monitoring Division who's going to give an overview of the ICF/DD Carve-In's Key Policy Requirements.

Dana Durham:

Great, thank you so much, Kristal. It took me a minute to find my buttons to begin with. So I will go through the Policy Requirements and if you'll take us to the next slide. Just a second. So effective January 1st of the coming year, so exactly a month from today, all

managed care plans will be responsible for the long-term care benefit at the following types of Homes: ICF/DDs, ICF/DD-Habilitative and ICF/DD-Nursing. ICF/DD-Continuous Nursing Care Homes are not included in the long-term care Carve-In. All Fee-for-Service Medi-Cal beneficiaries residing in ICF/DD, ICF/DD-H, and ICF/DD in-Homes are mandatorily enrolled into Medi-Cal managed care plan for their covered services.

Dana Durham:

And I see a question. Rick, I wonder if you can type your question into the chat if you have one. So, next slide please.

Dana Durham:

So, we have a lot of resources out there. And I'm going to give you an overview of the Carve-In documents and resources which are available on the ICF/DD Carve-In webpage. DHCS has recently released the updated APL. It's called an All Plan Letter, we refer to them as APLs. And Model Contract Language or as we refer to it often, it's MCL. Now several of the key updates include clarifying the timeline for initial authorization requests, and reauthorization that can be up to two years. Clarifying that Regional Center's determination of medical necessity applies to initial authorizations as well as reauthorizations. Updating the LOA to clarify that a physician's signature is required on an LOA only for members attending summer camp, providing guidance on the credentialing process, and releasing the MCP ICF/DD Authorization Request form. Now we'll provide more details on these updates throughout today's presentation. So, more to come. And we also want to note that DHCS and DDS have compiled up-to-date contact information for the plans Long-Term Services and Supports Liaisons and Regional Center's liaisons. We'll be sharing both of those lists with the ICF/DD Homes, Regional Centers, and managed care plans. Next slide, please.

Dana Durham:

So, we'll touch a little bit on contracting and credentialing. We know that many Homes and plans are working on setting up contracts. We do want to reiterate that the managed care plans are required to contract with at least one of each type of Home, prioritizing ICF/DD Homes in the managed care counties when available. More detailed network readiness guidance was provided to the plans separately. Managed care plans are required to incorporate language from the MCL or the Model Contract in addition to their contract language to help ensure consistent delivery of the ICF/DD Home services across plans. Additionally, managed care plans are responsible for credentialing providers. However, since ICF/DD Homes are subject to extensive regulations by various state departments, DHCS is allowing managed care plans to deem ICF/DD Homes credentialed through an attestation. Next slide please.

Dana Durham:

Here's an overview of what will be required as part of that credentialing process. For the initial credentialing process, Homes will need to submit the documents listed on the top half of this slide to manage care plans. Managed care plans need this information to

enter Homes into their systems and to be able to provide payment. Homes will also need to complete an attestation form, which was included as an attachment with the updated All Plan Letter. A sample of that form can be seen here. The attestation form will allow Homes to attest that the required documents are complete and on file with the appropriate entities. The documentation includes completion of the managed care plan's provider training, site visits, no change in ownership disclosure, CDPH licenses or certifications, and that the Home is in good standing as a Regional Center vendor. ICF/DD Homes will need to complete the attestation every two years to confirm recredentialing. Next slide please.

Dana Durham:

This is about authorizations. In Medi-Cal's Managed Care Program, managed care plans are required to support utilization management, which means that it's under their authority and responsibilities to approve or deny service authorization. In the case of ICF/DD Home services, managed care plans must utilize the determination and recommendation from the coordinating Regional Center and attending physician for a member's admission to or continued residency in an ICF/DD Home. This applies for initial authorizations as well as reauthorizations. Managed care plans are responsible for fulfilling existing authorization requests for ICF/DD Home services provided under the ICF/DD Home per diem rate for the duration of the treatment authorization. Data on existing Fee-for-Service authorizations was sent to all plans on November 7th. While data on existing authorizations has been sent to plans, we would also encourage Homes to share copies of the members' authorizations with their plans to ensure a seamless transition once the Carve-In goes into effect. Additionally, managed care plans are responsible for approving any new treatment authorization and reauthorization requests for ICF/DD Homes for up to two years. Managed care plans are responsible for ensuring members are receiving all necessary services and supports, so they may determine when reauthorizations are needed on a case by case basis. Next slide, please.

Dana Durham:

So, here's a brief overview of what the authorization process will look like under the Carve-In. Regional Centers will make eligibility determinations for ICF/DD services and will submit a referral packet to ICF/DD Homes for review. After receiving the Regional Center referral packet and confirming bed availability and capacity, the ICF/DD Home completes and submits the documents required for authorization to the member's managed care plan. Now these documents include the Certificate for Special Treatment Program Services form, which is HS-231. And this is a form that the managed care plans use as evidence of the Regional Center's determination that the member meets the ICF/DD Home level of care. It also includes the Medical Review/Prolonged Care Assessment (PCA) form, which is DHCS 6013A. They must also include the Managed Care ICF/DD Authorization Request form.

Dana Durham:

The Managed Care ICF/DD Authorization Request form was included as an attachment in the updated APL. It's intended for Homes to use when submitting authorization request for members who enrolled in a managed care plan. It includes a condensed list of data elements that are currently used on the Long-Term Care TAR 20-1 form, which that's the treatment the authorization request used by Medi-Cal Fee-for-Service. As Homes get accustomed to submitting authorization requests to plans, DHCS' Clinical Assurance Division has a process in place for handling any authorization requests that are improperly submitted to DHCS. The Clinical Assurance Division will deny any TARs and the Home will receive notification in the system. And Clinical Assurance Division will also notify the member's plan so that the plan can work directly with the Home on submitting the authorization request using the appropriate process.

Dana Durham:

And just to really codify what that's going to look like, you submit to DHCS and you shouldn't have, the Clinical Assurance Division will let the submitter of the TAR know, and also let the plan know so that that connection can be made and everyone knows the process.

Dana Durham:

And with that, I'm going to hand it over to Michael Jordan from the Capitated Rates Development Division to discuss ICF/DD Home payment rates under the Carve-In.

Michael Jordan:

Thanks a lot, Dana. Hi everyone, Michael Jordan here. We will now provide an overview of ICF/DD Home payment rates. So as shown at the top of the slide here, managed care plans must reimburse network providers that furnish the ICF/DD Home services and each network provider of these services must accept the payment amount that the network provider would be paid for these services in the Fee-for-Service delivery system.

Michael Jordan:

So, importantly, that does mean that the ICF/DD Home providers will not experience any decreases in the payments they receive with this transition to the managed care delivery system. So only ICF/DD Home services, or in other words, those services included in the ICF/DD per diem are subject to the state directed payment requirement. And there is a slight difference in this policy based on whether the county is newly transitioning.

Michael Jordan:

And so, what I mean by that is in counties where ICF/DD Home services benefit coverage is newly transitioning to managed care effective January 1, 2024. So, for these counties, managed care plans must reimburse network providers of ICF/DD Home services at exactly the Medi-Cal Fee-for-Service per diem rates. So, in other words, no more and no less than Fee-for-Service rate.

Michael Jordan:

On the other hand, in counties where ICF/DD Home services are already carved into managed care prior to January 1, 2024. In these counties, managed care plans must reimburse at no less than the Medi-Cal Fee-for-Service per diem rate, and that is the only requirement there. All other services outside of the per diem are not subject to the state directed payment, and instead, they are payable by managed care plans based on a negotiated rate with the provider. So, that concludes this slide and I would now like to turn it over to Kathy Nichols, our partner at Mercer, to talk about the ICF/DD Home per diem and more about the billing and payment process. Thanks.

Kathy Nichols:

Thank you. So, we also wanted to provide a brief overview of what's included in the ICF/DD per diem versus what is excluded. So, like Michael mentioned, the state directed payment rate applies to services included in the ICF/DD per diem, which includes all services, equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria. Some examples of what are included in the ICF/DD per diem rate are active treatment programming, administrative services, health supports, food and nutritional and pharmaceutical services and social services. It should be noted that there is some variation in inclusive services by ICF/DD Home type. Again, the services excluded from the per diem are not subject to the state directive payment arrangement. These excluded services are payable by the MCPs based on the rates negotiated between the MCP and the provider. And this would include services and supplies such as durable medical equipment, allied health services ordered by an attending physician, laboratory services, and dental services.

Kathy Nichols:

We also wanted to note that services and supplies billed separately are subject to the general provisions and billing limitation set forth in state regulation as listed on this slide. A summary of included and excluded services in the ICF/DD per diem rate can be found in Attachment A of the APL 23-023.

Kathy Nichols:

If we look at the next slide on billing and payment process, MCPs are required to establish processes that allow Homes to submit claims or invoices and provide payments to Homes in a timely manner. Under the payment processes, the MCPs must provide processes for ICF/DD Home providers to bill or invoice and receive payments in a timely manner and must have a process for ICF/DD Homes to submit electronic claims and receive payments electronically. For payment timeliness, additionally, in terms of payment timelines, MCPs are highly encouraged to pay claims and invoices in the same frequency in which they're received, whether electronic or paper. However, the MCPs must pay claims or any portion of any claim as soon as practicable, but no later than 30 calendar days after receipt of the claim. MCPs must also provide training to ICF/DD Homes on how to submit claims and provide sufficient detail of additional information as needed to process the claim.

Kathy Nichols:

If we continue on in the Billing and Invoicing Guidance, DHCS has released Billing and Invoicing Guidance, which can be found on the DHCS ICF/DD Carve-In website. The purpose of the Guidance is to standardize invoicing and claiming processes, minimize ICF/DD Home and MCP administrative burden, and promote data quality to support accurate and timely payments. The Guidance document defines the necessary data elements required for invoicing, including information about the member, the services rendered, the ICF/DD Home and some other administrative details. It also defines the file formats, transmission methods, timing and adjudication for claims and invoicing processes. Here you can see an overview of the submission options for Homes. This includes submitting claims digitally using an electronic data interchange. Homes can also submit claims using other nationally accepted electronic file format standards such as the forms that are listed here. And Homes also do have the option to submit manual invoices using a paper form of the UB-04 claim.

Kathy Nichols:

Now I'll turn over to Stephanie Conde of the Managed Care Operations Division to tee up a discussion on member outreach and communication efforts.

Stephanie Conde:

Good afternoon, everyone. Thanks, Kathy. I'm Stephanie Conde with the Managed Care Operations Division, I'm the Branch Chief with the Department and I am helping to oversee this project and the transition. I want to go over with you guys today, the member outreach and communications. Next slide please.

Stephanie Conde:

The Department is mailing notices to our long-term care members who are transitioning. We are mailing both to the member and to the Authorized Representative that is recorded in our Medi-Cal Eligibility Data System. We call that MEDS. We have mailed a 60-day notice to our members at the end of October and members should have that at the top of November, again, for a 60-day notice. And then we also did mail a 30-day notice more recently at the end of November and for an in hand date of December 1st. In the notices, there is a quick reference code, a QR code, that if the member scans the QR code, it goes to a Frequently Asked Questions – we call it a Notice of Additional Information – on the DHCS website. That document is in an FAQ format, so question and answer format with just additional information about the transition and how it may impact that member. Members that reside in our non-COHS, non-Single Plan counties also received my Medi-Cal Choice packet, which is an enrollment packet to enroll into a Medi-Cal managed care plan. And to know, members in what we call Matching Plan Counties did not receive those packets as they were enrolled into a matching Medi-Cal plan based on their Medicare enrollment. Following the 60, 30 day notices and when applicable, our Choice Packets DHCS is also conducting an outbound call campaign starting at the end of November and through January of 2024 for those transitioning members. On the right side here is a box with some resources on the DHCS website. It does include our member notices, so stakeholders and members can see a template of

what has been sent to the member, our Notice of Additional Information, and then an ICF/DD member transition fact sheet. Also, a very good resource. Next slide please.

Stephanie Conde:

So, supporting our ICF/DD Home , going over ways to support our members through their enrollment process into Medi-Cal Managed Care. So, for Medi-Cal, eligibility matters. An Authorized Representative or other legal representative may act on behalf of the Medi-Cal applicant or member. Regional Centers may act on the individual's behalf if they cannot act for themselves. A Home may be able to act on the individual's behalf if there is no spouse, conservator, guardian, or executor, and the applicant is not considered competent. So to assist that resident with Medi-Cal applications or renewals, the ICF/DD Home should contact their local county office, Medi-Cal office. So more specific to managed care plan assistance. Enrollment can be done over the phone, when talking to a customer service representative, it can be done online, or by mailing in a Choice Form. Or in person at one of our Field Operations sites.

Stephanie Conde:

Medi-Cal members or the representatives, including a Regional Center and ICF/DD Homes, may contact Health Care Options for plan enrollment assistance. And we have included the Medi-Cal Health Care Options contact information number. And I believe I'm going to hand it over to start off any kind of Q&A on this slide, this information, or previous slides.

Kristal Vardaman:

Great, thanks Stephanie. Thanks to all our presenters for providing those important updates. And now we're going to spend the remainder of our time today on this call going through stakeholder questions. Next slide please.

Kristal Vardaman:

So, a few logistics before we begin the discussion period. DHCS and DDS will begin with some questions that were submitted in advance via the Zoom registration form, as well as some questions that they didn’t have a chance to get to in past webinars. So, after the DHCS subject matter experts answer those questions, we'll open it up for questions from today's attendees, including I see one hand raised, we'll start off with that and then go to some of the questions that have come in through the chat. So, to ensure DHCS covers as many questions as possible, if you can please do submit your questions through the Zoom chat function. And if your question’s chosen and you’d like to provide more context or clarification, then you can also use the raise hand feature at that time in Zoom, and we can unmute your line for that.

Kristal Vardaman:

So, with that, we'll start off with some questions that were submitted prior to the call. I'll kick it off with some questions around billing and payment. The first question is: what should ICF/DD Homes do if they encounter challenges with claims denials or timely

payments? I think someone from our MCQMD colleagues will be able to respond to that one. Dana, or others?

Dana Durham:

Can you just repeat the question?

Kristal Vardaman:

Yeah. Sure. The question again was: what should ICF/DD Homes do if they encounter challenges with claim denials or timely payments?

Dana Durham:

Yeah, it's a good question. I mean, I will say that your first response should be to work with the plan and understand why there's a denial or untimely payment. Once you've done that and you can show us you've done that, you certainly can come to the Department and we will assist you in working through it, but we really believe it'll be a pretty good relationship. So, we'd want to make sure that you've attempted to work through the process before you come to the plan. I mean Department, sorry. You should go to the plan first. I don't know, maybe not enough coffee in this afternoon, so not sure why I'm having problems today.

Kristal Vardaman:

All good, thanks Dana. Next question we have again on the same theme of billing and payment, but this one might be best suited for DDS. It was about Regional Centers. So, if providers experience delays in payments from plans, are they able to receive support from Regional Centers?

Caroline Castaneda:

Yes, as a safety net, while ICF/DDs work out their billing processes with managed care plans, for an ICF/DD that might not get paid for more than 30 days after they've submitted a claim, and that can show that, the Regional Centers will be able to provide a temporary payment that is going to be expected to be repaid within 15 days of payment from the managed care plan. So, it is temporary, and it does require a quick repayment to the Regional Center, but it will be available. We are working on a single standard agreement, hoping that that will also streamline the operations for ICF/DD Homes and Regional Centers a lot.

Kristal Vardaman:

Great, thank you. Now we're going to turn to a couple of questions that came in around enrollment issues. And so, the first question is: what should a member do if they have not received a Medi-Cal Choice Packet?

Stephanie Conde:

Good afternoon. The member should reach out to Health Care Options. They can either take the enrollment over the phone or deploy a new packet with a Choice Enrollment

form. So I would recommend members would call Health Care Options and that number is in the slide deck.

Kristal Vardaman:

Great, thank you. I think we have another question, Stephanie, that might be for you. If the member's not considered competent and does not have a guardian, conservator, or other legal representative, who can sign the enrollment form on their behalf?

Stephanie Conde:

The enrollment form can be signed by… I guess it just depends on the scenarios. We covered a few scenarios where the ICF/DD Home or the Regional Center can assist that member. So, I think that there's just different scenarios, so it just depends. And I don't know who asked the question, Kristal, is it in the chat box and I can see who's asking it?

Kristal Vardaman:

This was one that came in advance of the call today.

Stephanie Conde:

Okay. Yeah, it just depends on the scenario, but yeah, someone who is representing the individual's best interest may be able to sign that form, but we also have a process as discussed earlier, that the member or the Representative can call Health Care Options and there's a way Health Care Options can assist through the enrollment assistance for a member who is not competent.

Kristal Vardaman:

Michelle, I see you came on. Did you have anything to add?

Michelle Retke:

No.

Kristal Vardaman:

Okay, great. Thanks. Next question, again around enrollment issues, but more around the Home side. So, do members need to be enrolled in the same plan that the Home has contracted with?

Stephanie Conde:

This is a twofold question. So, members have to be enrolled in a plan within their county. And there's specific data that drives that it's data in our Eligibility System. They have to live in a certain zip code to be able to be enrolled in that plan, but I do want our network folks to talk a little bit more about the Continuity of Care for members residing in a county where there might not be a contract with that facility. So I will pause and maybe Dana can jump in.

Dana Durham:

Yeah, thanks for the opportunity. So the goal is not to disrupt where people are if they're satisfied with where they are. Part of Continuity of Care is really honoring the existing authorization. So you may not be in the county where your eligibility is, but we will have the plan honor the authorization for up to 12 months as they work with the individual in the Home to make sure that that's the appropriate place for the individual and that the Home wishes to come into contract with the managed care plan. So, the process is to honor what's there, and really get the individuals in the appropriate place. Now, it could be a Letter of Agreement if it's a ways off and there's a reason that someone is there and not a full contract, but the goal is to make sure that people are as close to where they need to be as possible, that we have the right address for them and that there's no disruptions in care. And maybe I overcomplicated it, but just really want to make sure that it's clear that the goal of everything is to make sure that, for the member, this transition is as seamless as possible and that they're at the place that works best for them.

Kristal Vardaman:

Great, thanks Dana. And the last question we have around enrollment, preplanned question, at least, is: if a Home contracts with more than one plan, which plan should the residents enroll in and which plan does the Home bill? So, again, if there's more than one plan option and the Home has contract with multiple plans, are there a particular plan residents should enroll in such that the Home should bill them?

Stephanie Conde:

The last part on the billing, again, I'll let Dana comment to you, but if there's multiple plan options in the county and that that provider is contracted with more than one plan, that member can choose either plan. It's really based on the member's choice. So, I think the member can go to either plan because the provider is contracted with them, but the billing part, I don't know. Dana, if you want to jump in.

Dana Durham:

Can you restate the billing part, Stephanie, because I thought this was for you, so it wasn't as cognizant of-

Kristal Vardaman:

Dana, the question was just if a Home has a contract with multiple plans, which plan should the residents enroll in? And then which plan does the Home bill? Was the second part of the question.

Dana Durham:

The Home will bill the plan that the member is enrolled in, so just want to make that really clear. But I'd also say, you know, long-term it’s beneficial to make sure that you have good relationships or at least establish relationships with all the managed care plans in the area. I know the plans want to establish those relationships. And we really

don't want it to be that all of a sudden, you've got someone, they want to come to your Home, and you're trying to make it all work together. The goal is that a lot of this can be done over the next year so that there are no concerns longer term. So when I look at it really is let's try during this year to make sure that we establish those relationships and get those contracts in place so that no matter what your member chooses or your resident chooses at any point that you've got a contract and they can have that choice to switch if they want to or do what they want to do that best meets their needs.

Kristal Vardaman:

Great, thank you. That's the end of our pre-planned questions. So, I'm going to go to Rick, I see your hand's been up. I'm going to ask the team to unmute you and then we have some questions that have come in from the chat.

Rick Hodgkins:

Okay. First off, a follow-up comment from our meeting two weeks ago. I'm not in an ICF/DD, I receive ICF services. Sorry, my video is off because I'm multitasking here.

Rick Hodgkins:

Okay, a couple of things, a couple of questions. Rather than having the ICF/DDs, MCPs and Regional Centers, rather than encouraging them to communicate, shouldn't they be mandated or mandatorily required to communicate? I mean if we're going to mandatorily have most people in Medi-Cal managed care plans, then this requires – I feel, that there should be a mandate requiring all the parties involved to communicate. Everybody that's making the decisions. And second, somebody mentioned CDPH offices in the counties. I never heard of the California Department of Public Health having offices in every county. I know that here in the Sacramento County near the capital that we have the Department of Public Health, but I didn't know that there were. And what does Public Health have to do with this? That's all. Thank you.

Dana Durham:

Sure. I'll start to answer that and then if others have responses, feel free to chime in. First of all, thanks for your questions, Rick. I do appreciate them. I will say that the parties are really required to have relationships and communicate, and if that wasn't really codified as much, I appreciate the ability to clarify. We do require MOUs between the parties so that we just know that that conversation is happening and those MOUs do have a requirement to have regular meetings and the agenda items for those meetings will be posted just so we just know that that conversation's happening. As far as CDPH being in each county, that probably was a misstep a little bit. CDPH is a state entity that does have oversight over Homes. There is Public Health representation, but that is run by the counties, not the Department of Public Health overall. But to be licensed a Home does have to go through the California Department of Public Health's process.

Kristal Vardaman:

Great, thank you. Dana. Lupe Henry, I see that you have a couple of questions in the chat. I was actually going to ask one of them now. So, I'll have the team unmute you so

that maybe you can provide some context for some of them. One of the questions that I wanted to kick off this with was around who will pay for custodial care to the ICF/DD-H or -N, the managed care plans or the subcontractors specifically pertaining to Kaiser as a subcontractor. And there was another question that similarly came in from Stephanie Schram from Contra Costa Health Plan, is KP responsible for managing the custodial benefit portion of the Medi-Cal benefit for their members? So, I don't know if someone is online that can answer that. And then also Lupe, if you wanted to expand on that question.

Dana Durham:

Lupe, I might ask you a follow-up question. Kaiser is going into several counties as a primary contractor instead of a subcontractor. So just want to make sure you're aware of that before we think through your question, because Kaiser will be directly responsible for individuals. And secondly, you would want to make sure that you have a relationship with the contractor and the subcontractor to know how that works. Ultimately, the main contractor is responsible for payment, but sometimes that process is delegated to a subcontractor and your managed care plan will help you know exactly the process to go through. And I hope that answered your question, but I think they unmuted you, Lupe. So, happy to answer any follow up.

Kristal Vardaman:

Lupe, we can't hear you if you're trying to speak or… you should be unmuted. So, if you can't speak now and have some follow-ups, maybe you can type it in the chat and we will return it to you if we can. Great.

Kristal Vardaman:

Okay. Let's see. The next one. Looking at some other questions that have come in from the chat, I know we've answered some questions in the chat, but there's some that may be worth reemphasizing here on the call as well. One question that came in, Stephanie, I see you responded to it was around, when Heather from North Star Care asked when trying to enroll in the Health Care Options website, some individuals are showing up as ineligible. What do we need to do for this issue? If others are having that issue, what should be their next steps?

Stephanie Conde:

Thanks, first of all. You can always call Health Care Options, but I did put my email in the chat, specific to Heather, if you'd like to email me, I do have a team that I can work on it. We can look into what's going on.

Kristal Vardaman:

Okay. Great. , next question, we have a question from Anne Bolus from Solidum Care Home ICF/DD-N. If our consumers choose an MCP or are automatically defaulted to a random MCP that our facilities are not contracted with, what will happen and what is the process?

Dana Durham:

Go ahead. Go ahead, Michelle.

Michelle Retke:

Oh no, I was going to say it’s really about the continuity piece for you to jump in on. So, I'm here to support.

Dana Durham:

Oh great, thanks. So, members do have a choice and we have, as we said, given authorization and are making sure that the authorization information is transmitted to the managed care plans. It's a lot of information, so it's taking a little while for them probably to work through it. If you haven't gotten a contact from them yet, you have a member who's going to be in a plan or has chosen a plan. I would say that if you're aware of the plan that the member has chosen, that you should reach out to that plan and start that conversation. And if you haven't heard from the plan and a member's being defaulted, there may be a little time before that actually takes place that the plan contacts you. But as I said, we would like for you to be as proactive as possible in reaching out to the plan and having that conversation.

Dana Durham:

Or if any reason that someone is your Home and that conversation hasn't happened yet and they're enrolled in a plan and don't know about it, we would ask that you make sure that the managed care plan has a copy of that authorization and that you talk to them about that authorization. Say you're on January 15th and for some reason that information hasn't gotten through well, or that if that individual is in your Home, talk to the managed care plan and they will work with you through the process. The idea is to make it as seamless as possible for you and for the member. So, there might be a time in which that connection isn't made well, but start with the managed care plan in which the individual's enrolled, and they will work with you to make sure that you're made whole through that process. And if there are any issues with that, feel free to contact the Department and we'll help you work through it. And Michelle, you might add something to that, but that's-

Michelle Retke:

Nope.

Kristal Vardaman:

And Dana, there was another question around is it suggested that Homes contract with all plans in their area and it sounds like you get some thoughts around the value of this year of continuity and how building relationships.

Dana Durham:

Yeah, I mean it's been my experience that the Homes and the plans really want to start building that relationship and working together. And you might not have a resident in a

plan right now or that's going into one, but if there's a plan in your area, start building that relationship and you can already go ahead and start working on a contract of some sort that specify the terms when you have an opening that someone might be put into or choose to be in your facility. The goal is to not have that be an emergency as that comes up, but to make sure that that relationship's already there. So that is an option for you and for the member and for the plan. I know that there are not enough Homes in California and that we need more spaces and we are so grateful for the providers who have those Homes and want to make sure that's an option for individuals. So as much as you can make sure that you go ahead and start those conversations, I'd encourage you to, so that you are an option for the managed care plans.

Kristal Vardaman:

Great, thank you. Before we move on to some other topics, Stephanie, I saw you had a note in the chat that there was a question you wanted to return to.

Stephanie Conde:

Oh, okay, thanks, Kristal. I did want to return to one of the questions that was asked earlier. I thought it maybe had to do with a specific facility or center that might have asked, but I do want to provide clarity around this as it has been a frequently asked question, so I just want to make sure to say it a little bit clearer. The question earlier was if the member is not considered competent and does not have a guardian, conservator, or other legal representative who can sign the enrollment form on the behalf of that member. I do want to point out that the Choice Form does indicate the enrollment form can be signed by head of household or Authorized Representative, but it does not have to be the authorized representative as indicated in our Medi-Cal Eligibility System. The directions include that the Choice Packet can be signed by the applicant or representative who is acting on behalf of the member. So, just to be clear, this could be the ICF/DD Home, a family member or case manager. So I just wanted to provide a little bit of clarity around that one. Thanks, Kristal, for the opportunity.

Kristal Vardaman:

Great, thank you. The next question we have, it came in from the chat that we haven’t had a chance to answer yet. This is a question around medical supply. So the question is how will the plan enrollment affect the member’s medical supplies? So, incontinence supplies and also DME equipment? Does the medical supplier and DME provider or pharmacy need to be contracted and in network with the managed care plan?

Kristal Vardaman:

I think this might be a question for MCQMD. And we have a similar question too that also came in: does the facility physician need to be contracted with the MCP to order tests, referrals, et cetera? So, these are contracted providers outside of the Home itself. Dana or Bambi, perhaps?

Dana Durham:

I'm answering on mute. It's going to be one of those days. Thanks for the questions. It would behoove the provider to make sure that they have a contract with the managed care plan and the managed care plan will want to contract with the provider because they want to make sure that that Continuity of Care is continued.

Dana Durham:

There are a couple of things, to become a provider with the managed care plan, you do need to go through the provider enrollment process, and then you would work with the managed care plan to be a provider and to come into their network. But they can start with having you be able to care through the Continuity of Care before you become a provider. We do ask that you and/or the member or an authorized rep reach out to the plan and request that Continuity of Care of your provider, just because that's the process.

Dana Durham:

Whereas the Home Continuity of Care is just automatic, for a provider, it does take the provider actually reaching out, or the member, or the Home, to request that continuing relationship. As far as the incontinence supplies, pharmacy is carved out of managed care and there are specific rules around some of the supplies. I saw someone started to answer that in the chat but don't really know that as much. So, I'll pause for a minute to see if there's a friend who can offer a lifeline, or if not, we certainly will take that question back and answer it.

Bambi Cisneros:

And I think I would just add to that that we did share data with the managed care plans on the services and providers that the members are using so that the managed care plans could work towards contracting with those providers to continue providing those services. But just to highlight that the managed care plans do provide all medically necessary covered services, whether in network or out of network, but I think to Dana's points, it would be advantageous for the provider to be contracted with the managed care plan for continuity purposes.

Kristal Vardaman:

Great, thanks. And Dana, I think the next question is likely for you as well. This is around contracting and payment issues. So can you please clarify that even if a provider is not contracted with a plan, they're still required to pay clean claims within a maximum of 30 days, preferably quicker, correct? This question.

Dana Durham:

So clarifying a couple of things. One is on the Continuity of Care piece, the provider must really make sure that if they're a Home that the plan would just automatically work on that Continuity of Care if they’re a provider that's not a Home, there are a few different rules that must be followed. Just noting that at first. And I just talked about that. But I would say that the payment for the 30 days, someone should be paid in that timeframe. If there's a clean claim, the requirement is actually for those who are in

network, which means that you have a contract. And the plans are working to make sure if they have a clean claim, it is paid timely. So just want to nuance that a little bit, but not really say that that's not going to happen, because I think the commitment is there to make that happen if it's an appropriate claim. There are a lot of variables, so I don't want to overpromise, but I know that there is goodwill and there is commitment to make sure those claims are paid timely.

Kristal Vardaman:

Thank you. And Dana, I think Adrienne answered this question in the chat, but just to maybe emphasize since we've been talking about clean claims, could you just describe what it means to have a clean claim?

Dana Durham:

Sure. A clean claim is a claim that meets all the specifications that are included in a claim. And so that means you have the right billing information that the managed care plan has said is needed. Do you have the right information about what you've done? Is your invoice or your claim correct? And if not, if you have questions, the plan has individuals who will work with you. So, for instance, I will say that that Long-Term Services and Support Liaison is there for that exact reason. You have some concerns about how to submit a claim and you're just not sure, that person will work to help make sure that you understand it and your claim is clean.

Kristal Vardaman:

Thank you. I think we have time for a couple more questions. Next question we have from Matt from Arc of San Diego. What happens if a client is enrolled in a Medicare Advantage plan associated with a Medi-Cal HMO that isn't a designated HMO in our county? Will they be defaulted into the plan associated with the Medicare Advantage plan? And will Homes have to contract with that plan too?

Stephanie Conde:

Hi, good afternoon. Is there a county associated with that question? I just want to make sure. It just depends, Matt. I think it was Matthew, about if that member resides in a Matching Plan County or not.

Kristal Vardaman:

And Matt, if you wanted to come off mute to provide any context, but again, Matt's with the ARC of San Diego.

Stephanie Conde:

Oh, San Diego? Thank you. So, San Diego is a Matching Plan county. So, if the member is in a Medicare plan that does match a Medi-Cal plan, then they will be automatically enrolled. Now if they're in a Medicare plan that doesn't have a match in San Diego, they won't be automatically enrolled into a plan.

Kristal Vardaman:

Okay. Last couple of questions. One around credentialing. For initial credentialing of the ICF/DDs, plans must provide, it's the site survey and CDPH license to the plan, is that correct?

Dana Durham:

Can you go back to that slide? It really specifies what is required. Now I will say we work very hard to streamline that process overall so that there's not deviation from plan to plan and to make sure that it's very clear. I am asking her to go back to that slide because I think it becomes the one that really has all the information that we really need and that will be required. I think it's before that.

Kristal Vardaman:

Here we go.

Dana Durham:

On the one that says credentialing. The second one.

Kristal Vardaman:

Yes.

Dana Durham:

Yeah, that one. So you need the W-9, you'll need the Ancillary Facility Network Provider Application, certificate of insurance, and your county business license, as well as the attestation. Now, much of what is in the attestation, well everything that's in the attestation, is a process that's done by another agency and the attestation will just assure that you've gone through that process and able to plan to know that you've done what needs to be done with either CDPH or DDS. I think one of the things we've responded to and be very cognizant of is there are a lot of oversight in this area and we've done what we can to make sure that the oversight is lessened through this credentialing process as much as possible.

Kristal Vardaman:

Great. Thank you.

Dana Durham:

But I hope this slide is helpful and kind of answers your question a little bit better.

Kristal Vardaman:

Great, thanks. So, I think we're coming close to time. So, thanks to everyone for your thoughtful questions, and discussion, and thanks to the presenters and DHCS subject matter experts for answering questions today.

Kristal Vardaman:

With the last few minutes, we'd like to share some resources Homes can use to learn more about the ICF/DD Carve-In and where you can go for more information if we weren't able to get to your question today as well. So as mentioned earlier in the webinar, there are a series of resources that are available on the ICF/DD Carve-In webpage, including the APL, Model Contract Language, Frequently Asked Questions, and the Billing and Invoicing Guide. You can find more detailed descriptions of these resources including changes that have been made since the initial release in the appendix of this slide deck once it's posted. We'd also encourage you to check out the ICF/DD Member Information webpage where you can find copies of the member notices and the Notice of Additional Information. Next slide please.

Kristal Vardaman:

And here we are going to have an overview of our webinars for the ICF/DD LTC Carve-In. The next webinar is focused on Medi-Cal Managed Care Supports for ICF/DD and Subacute Care residents. And that will be taking place on Friday, December 15th at 9:00 AM. And please visit the Carve-In webpage for any additional updates and resources, including materials from previous webinars and information on the one that's upcoming. Next slide, please.

Kristal Vardaman:

And if you have any additional questions, please email the new inbox, the LTCtransition@DHCS.ca.gov that's linked on this slide, again, once it's posted, it will direct to DHCS subject matter experts who can get back to you about the answers to your questions. And with that, thank you very much for attending today's webinar. Hope you all have a great weekend. Thanks.