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SPEAKERS

Kristal Vardaman
Bambi Cisneros
Dana Durham
Michael Jordan
Jim Knight
Stephanie Conde

Kristal Vardaman:

Hello, everyone. Good morning and thank you for joining today's session, CalAIM Intermediate Care Facility for the Developmentally Disabled, or ICF/DD Home 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 PowerPoint slides, and the meeting materials will be available on the DHCS ICF/DD LTC Carve-In webpage, and you can find a link to that webpage in the Zoom chat momentarily. Next slide, please.

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 with your organization, which will help us to track any questions if we need to follow up with you. To do this, click on the "Participants" icon at the bottom of the window, hover over your name in the "Participants" list on the right side of the Zoom window, and then select "Rename", and then enter your name and add your organization as you'd like it to appear. Next slide, please.

Kristal Vardaman:

I have a few housekeeping notes before we begin. Again, this session is being recorded and the slides and recording will be posted to the LTC Carve-In webpage. Participants are in listen-only mode right now, but can be unmuted during the Q&A discussion. We'll ask people to unmute themselves in order to clarify, add some additional context to the questions in the chat. So during that time, you'll be able to raise your hand and someone from the team will unmute you.

Kristal Vardaman:

You can also use the chat feature throughout the presentation to submit any questions. As you do that during the presentation, our team will be monitoring them, and we have a designated time after the initial slides for Q&A, both some prepared Q&A, as well as taking some of your questions from the chat. Next slide, please.

Kristal Vardaman:

And here's the agenda for today's session. Again, we'll start off with a brief overview of the ICF/DD Carve-In, key policy requirements, and some promising practices. And then we will have an opportunity to discuss stakeholder questions, starting off with some questions that were received on recent webinars and those that were submitted in advance of today's session before we open it up for questions from attendees. And then finally, we will wrap up with some next steps and closing.

Kristal Vardaman:

So now I will turn it over to Bambi Cisneros, who's the Assistant Deputy Director of Health Care Delivery Systems, to give you an overview of the Carve-In key policy requirements.

Bambi Cisneros:

Hello, everyone. Good morning and thank you for joining us on Office Hours today. So, we can go to the next slide, please, to talk a little bit about the ICF/DD Carve-In and provide a brief overview.

Bambi Cisneros:

So, on January 1, 2024, all managed care plans are now responsible for the full long-term care benefit for ICF/DD Homes, and these include the ICF/DD-H for Habilitative and ICF/DD-N for Nursing. Wanted to also reiterate that there is an ICF/DD-Continuous Nursing Care type of Home that is not included in the Long-Term Care Carve-In so wanted to make you aware of that as well. So, what this means is that all Fee-for-Service Medi-Cal members that is residing in an ICF/DD Home that was subject to the Carve-In are now mandatorily enrolled into a Medi-Cal Managed Care plan so that they continue to receive their Medi-Cal covered services. Next slide, please.

Bambi Cisneros:

So here on the slide is really an overview of the guidance documents and resources that was developed in a partnership in consultation with the ICF/DD Workgroup, which is available on our ICF/DD Carve-In webpage. In November, the Department did release an updated All Plan Letter and Model Contract Language. The Department also released an updated version of FAQs in late December and an updated Resource Guide in January, which provides additional details on member eligibility and enrollment support, billing and payment, and provides a crosswalk of Fee-for-Service and managed care policies, which we also included as an appendix in this slide deck, and it really just goes through what was current state when things were in Fee-for-Service versus what has changed or will change as an effect of being in managed care.

Bambi Cisneros:

We are also having stakeholders check out the ICF/DD Carve-In Resources Roundup. We're calling it the Resource Roundup because what it does is it compiles all of the various policy documents. That was developed on one page. We have posted it on our website for an overview of any changes made to the Department’s policies. And so we really wanted to make sure everyone had the latest and greatest versions as there were iterations of some of these policy documents. So for the source of truth, we would direct you to the Resource Roundup. Next slide, please.

Bambi Cisneros:

So, in addition to the Carve-In resources that we have on our website, we also wanted to take a brief moment to highlight two particular forms here that’s implemented for this Carve-In. So these forms, which is the ICF… T’ey're referenced in the ICF/DD APL, and these forms will be submitted by Homes to the managed care plans for credentialing, and that’s the ICF/DD Credentialing Attestation Form, and new authorizations or

reauthorization requests, and that’s the screenshot on the right side of the slide here, the [MCP] ICF/DD Authorization Request [form].

Bambi Cisneros:

So, these forms were originally distributed to managed care plans and ICF/DD Homes via email in December of 2023 and will soon be available on the DHCS APL webpage. We are just undergoing some ADA accessibility remediation activity, so it'll be posted there. But wanted to then share here with this group that there have been no changes made to the content of these forms since they were originally distributed in December. So just wanted to raise that here, just seeing that we had some providers and plans just wanted to confirm the right versions of these forms. So no changes have been made to the content of these forms since they were originally distributed in December. We can go to next slide, please.

Bambi Cisneros:

Okay, so the ICF/DD Home Transition Timeline. So, this and the next slide really just shows a high-level overview of the progress that we've made so far in the Long-Term Care Carve-In Transition for the ICF/DD Homes and what stakeholders can expect during the implementation phase of the transition. So here, we have laid out the activities, resources, and efforts that were made in 2023 in preparation and leading up to the transition of ICF/DD services to managed care January 1, 2024. So, you see here that we have been sharing data with the managed care plans, and we've issued a slew of guidance, including Billing and Invoicing Guidance, the All Plan Letter, and then the Model Contract. And this Model Contract lays out the standard terms and conditions between the managed care plans and the ICF/DD Homes, and so that went out in the fall.

Bambi Cisneros:

With the release of those documents, we then anticipated and expected managed care plans to begin outreaching to Homes starting then. And then we do see that activity as ongoing as plans continue to contract with Homes throughout 2024. So there was a start period and then there's some ongoing work there.

Bambi Cisneros:

Later in the fall, we did continue to release additional documentation as you see listed here, including the Model Contract language. There were 60-day Notices that were sent out to members. The Regional Center Directive Letter was also released, and additional kind of data sharing from the Department to the managed care plans, really to help the plans do outreach to Homes and really kind of prepare for Continuity of Care arrangements that plans need to make. And then finally in December, the 30-day Notices went out and plans began to credential the ICF/DD Homes.

Bambi Cisneros:

The next slide then takes us from January 1, 2024, which is the go-live of the transition, and all the way through the end of 2026.

Bambi Cisneros:

So, taking a look at 2024, we see that as of January 1, Continuity of Care is now in effect for all Medi-Cal members that are residing in the Homes in their pre-existing providers for 12 months. And then of course, members can request a second 12 months of Continuity of Care in December.

Bambi Cisneros:

So also, now starting in January, Home providers will submit these new authorizations and reauthorization requests to the managed care plans. Previously, they were directed to Fee-for-Service Medi-Cal. And so now with the managed care plans being the payer, Homes will be sending the authorizations and reauthorizations to the managed care plans.

Bambi Cisneros:

When it comes to contracting and credentialing, that is underway. Homes and managed care plans should be working on that contracting and credentialing process. Ideally, Homes should have completed credentialing by the end of January, but we understand contract may be ongoing as Homes work to contract with the managed care plans that their members are enrolled in.

Bambi Cisneros:

And then just a little place-marker here about the Department developing a Quality Monitoring Plan with additional details still to be released, taking into consideration feedback that we received from the ICF/DD Workgroup, there's going to be more guidance and more to come on that. We're not going to have plans submit any kind of Quality Monitoring Reports until 2025, but again, more details and more to come on that in the quality monitoring space.

Bambi Cisneros:

And then at the end of 2025, Continuity of Care will be discontinued because the Department does expect managed care plans to turn these Continuity of Care Agreements into Network Agreements. And then finally, in 2026, managed care plans will then begin recredentialing Homes.

Bambi Cisneros:

So with that, I will transition it over to, I believe, Dana, to talk about contracting.

Dana Durham:

Thank you so much, Bambi. My name is Dana Durham. I'm the Division Chief for the Managed Care Quality and Monitoring Division. And as Bambi said, we're going to talk about contracting.

Dana Durham:

So managed care plans are required to maintain an adequate network of ICF/DD, ICF/DD-H, and ICF/DD-N Homes that are licensed and certified by the California Department of Public Health. And the managed care plans must report contracting status at the time of network submissions. Guidance on contract readiness or network readiness has previously been shared with the managed care plans and they're required to incorporate the standard terms and conditions from the Model Contract Language when contracting with the ICF/DD Homes. The ICF/DD Home Model Contract Language helps ensure that there's a consistent delivery of ICF/DD Home services within Medi-Cal Managed Care. In addition to contracting with ICF/DD Homes, managed care plans must also access the various providers that may be currently involved in the care of ICF/DD members and are delivering Medi-Cal-covered services so that they can also bring those providers into their network.

Dana Durham:

So DHCS sent transition data to managed care plans in November, and that data includes Fee-for-Service utilization claims data from the past 12 months, and that data is intended to help managed care plans, identify other providers that may be providing services to members and bring those into their network. Next slide, please.

Dana Durham:

So next we'll talk about credentialing. And as we talk about credentialing, I want to reiterate that managed care plans are responsible for credentialing providers. However, since the idea of ICF/DD Homes are subject to extensive regulation by various state departments, DHCS is allowing managed care plans to deem ICF/DD Homes credentialed via an attestation. So I'm going to give an overview of what will be required as part of the credentialing process.

Dana Durham:

Homes will need to complete an Attestation Form, which you saw that on the earlier slide. The Attestation Form allows Homes to attest that the required documentations are completed and on file with appropriate entities. This documentation on the left side of the slide includes completion of the managed care plan’s provider training, site visit, No Change in Ownership Disclosure, CPDH licenses, 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 for re-credentialing. For the initial credentialing process, Homes will also need to submit the documents listed on the right half of this slide to the managed care plans. Managed care plans need this information to enter Homes into

their systems and provide payments. And as you see, that's the W-9s, the Ancillary Facility Network Provider Application, the Certificates of Insurance, and the City or County Business License. With that, we'll go to the next slide.

Dana Durham:

Managed care plans must automatically provide 12 months of Continuity of Care for ICF/DD Home placement and any member residing in an ICF/DD Home that undergoes a mandatory transition into a managed care plan after January 1st of this year. Automatic Continuity of Care really means that members currently residing in an ICF/DD Home don't have to request Continuity of Care to continue staying in the Home they're in after January 1, 2024. Managed care plans are responsible for determining if members are eligible for automatic Continuity of Care using the data that's provided by DHCS prior to the transition. So if an ICF/DD Home still doesn't have a contract with the managed care plan after this initial Continuity of Care period, as Bambi talked about earlier, members and their representatives are entitled to request an additional 12 months. But instead of that being proactive by the plan, the member or the representative would have to initiate the request.

Dana Durham:

Continuity of Care also provides continued access to covered services, but there may be a switch to an in-network service provider in some cases. And those where there may be required switch, those include Non-Emergency Medical Transportation, Non-Medical Transportation, a specific facility, professional services, and select ancillary services as well as Care Coordination. Next slide, please.

Dana Durham:

In Medi-Cal's Managed Care programs, managed care plans are required to support utilization management. And just in simple terms, that means that the managed care plan is responsible to approve or deny services. 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. The 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 existing treatment authorization. So, data on existing TARs for the ICF/DD Home members was sent to the managed care plans in November. Additionally, managed care plans are responsible for approving any new Treatment Authorization and Reauthorization Request for ICF/DD Home services for up to two years.

Dana Durham:

Now, for new authorization requests, ICF/DD Homes are required to submit a few documents. Those documents include the Certificate for Special Treatment Program Services Form, and that's HS-231, the Managed Care ICF/DD Authorization Request Form or a plan-specific form with the same data elements, and the Medical

Review/Prolonged Care Assessment form, or form 6013A. It's really important that you note that the Managed Care ICF/DD Authorization Request form is used instead of, so it's a replacement for, the LTC TAR 20-1 form for managed care plan members. Next slide, please.

Dana Durham:

Now, I want to reiterate that some of the best practices that managed care plans and Homes have been documented, and we want to use those best practices to support Continuity of Care and authorizations. So for Continuity of Care, some of the promising practices really are sharing the members IPP and ISP with the managed care plan. And although sharing a member's IPP and ISP is not generally required, sharing all the planning documents can really give the managed care plan a better understanding of the members' whole needs. We're trying to treat the whole person, so what's going on with them? And it really could be instrumental in ensuring that a smooth transition and that there is continuation of all services and supports.

Dana Durham:

ICF/DD Homes are encouraged to share member's TARs with the managed care plan to which the member belongs. And while DHCS has provided all managed care plans with information about approved TARs for current ICF/DD Home residents, further coordination between the Homes and the managed care plans really will help ensure seamless transition of services and prompt payments.

Dana Durham:

When it comes to new authorizations or reauthorization requests, managed care plans should communicate requests for any supporting documentation in a timely manner. Additionally, managed care plans and ICF/DD Homes may use contracts or policies or procedures to ensure clarity and a coherent authorization process. So that includes establishing escalation contacts at the managed care plan in an event that an authorization delay occurs, and really creating and sharing those retroactive authorization policies that allow providers more time to submit authorization requests.

Dana Durham:

And finally, managed care plans are encouraged to approve authorizations for two years for members unless an individual's member's needs or circumstances warrant looking at that authorization on a more frequent basis.

Dana Durham:

With the end of this slide, I'm going to turn it over to Michael Jordan from the Capitated Rates Development Division and he's going to go over payment rates and processes.

Michael Jordan:

Hey, everyone and thanks, Dana. We will now go over an overview of ICF/DD Home payment rates. So managed care plans must reimburse Network Providers furnishing ICF/DD Home services to a member, and each Network Provider of ICF/DD Home services must accept the payment amount that the Network Provider would be paid for those services in the Fee-for-Service delivery system. And this means that ICF/DD Home providers will not experience any decreases in the payments they receive. So only ICF/DD Home services, in other words, those services included in the ICF/DD per diem, are subject to this state-directed payment requirement. There is a slight difference in policy that we'd like to cover here based on whether the county is newly transitioning to managed care.

Michael Jordan:

So, in counties where ICF/DD Home services benefit coverage is newly transitioning to managed care on the first of the year, 1/1/2024, managed care plans must reimburse Providers of ICF/DD Home Services for those services at exactly the Medi-Cal Fee-for-Service per diem rates.

Michael Jordan:

And then on the other hand, there are counties where ICF/DD Home services are already carved into managed care prior to the first of the year. So managed care plans in these counties must reimburse Network Providers of ICF/DD Home services for these services at no less than the Medi-Cal Fee-for-Service per diem rate, so just that floor at the Fee-for-Service rate. I do want to mention that all other services outside of the per diem, which are also referred to in these slides and in conversations as excluded services, these services are not subject to the state-directed payment. Instead, these services are payable by MCPs based on negotiated rates with the provider.

Michael Jordan:

And lastly, wanted to mention here at the bottom, for a summary of these included and excluded services for ICF/DD per diem rates, please refer to Attachment A of APL 23-023. Next slide, please.

Michael Jordan:

So for billing and payment processes, this slide lists several additional requirements for MCPs when it comes to billing and payment. MCPs must have a process for ICF/DD Homes to submit electronic claims, and also to receive payments electronically. We also do know not all ICF/DD Homes are able to submit electronic claims, so MCPs must also allow an invoicing process. And there are some submission methods listed here on the slide as well as forms and formats. You can take a look at that here. This is an overview. This includes submitted claims digitally using electronic data interchange. Homes can also submit claims using other nationally accepted electronic file format standards such as the forms listed here. Also, manual invoices can be submitted using

a paper form of the UB-04. More details about invoice submission can be found in the billing and invoicing guidance that was mentioned earlier in this presentation.

Michael Jordan:

In terms of payment timeliness, managed care plans are highly encouraged to pay claims and invoices in the same frequency in which they are received no matter if they're electronic or paper. However, we do want to mention that MCPs must pay claims or any portion of the claim as soon as practicable, but no later than 30 calendar days after receipt of the claim.

Michael Jordan:

And lastly, on this slide, we do want to note that MCPs must also provide training to ICF/DD Homes on how to submit claims and provide sufficient detail if additional information is needed to process that claim.

Michael Jordan:

So that concludes these two slides and I'd like to transition it over to Jim Knight from DDS to discuss the Regional Center Lag Funding Agreement. Jim, over to you.

Jim Knight:

Great, thank you, Michael. So as it says, the Regional Center Lag Funding and just for some background, “lag funding” or “lag” refers to if there is a delay in payments from the managed care plans and the Regional Centers can provide assistance when there is that delay. So essentially then these payments are a loan to cover the period of time in between the submission of claims and when those claims are reimbursed from the managed care plan.

Jim Knight:

We've got some of the bullets, and I'm going to talk about the first one in particular where it says that with the agreement that went out, it says that the ICF/DD Home would attest that they've submitted claims to the plan and have not been reimbursed. We've heard there's been some delays even in being able to submit those claims, so we are going to adjust this to take out the requirement of actually submitting the claim. We'll have that adjustment likely by early next week and we'll communicate that out to everyone because we still want to make sure that the payments can be... There's not the continued delay in waiting for even the submission. But we will still contain, and the agreement says that are linked below, that the Home would have to then agree to reimburse the Regional Center within 15 days once they do ultimately receive payment from the managed care plan.

Jim Knight:

And this says right now, the Lag Agreement also says, and it's a standard agreement used by all Regional Centers and Homes, says that the period that this would be applied to is through June service. June of this year. However, that date will be modified or extended if there is a need. So really at this point, it is temporary, but we will modify that if needed.

Jim Knight:

So, the agreement that's... And I'll go over it briefly here. We will also set up specific times for Regional Centers and Homes to have trainings just on this lag funding process. But in general, the agreement requires that the Home not only is vendored but obviously licensed, which obviously you are if you're providing those services, and then attest to that the Home will do the repayment and that they have submitted claims, although that attestation of submitted claims to the managed care will be modified. So, there will not be a requirement to submit any documentation to show that a claim has been submitted; it's just an attestation that the Home is continuing to work and take steps to try and do what's necessary to get the reimbursement from the managed care plan.

Jim Knight:

So, that's the initial agreement would be signed one time, and then the Enclosure B that's referenced there is an attestation that would be submitted each time a claim is submitted to the Regional Center for lag payment. Again, one of the attestations on there now is that the Home has submitted claims and it's been at least 30 days since that submission has occurred. We will modify that and get that out, like I said, early next week.

Jim Knight:

So Homes, Regional Centers have this. We've asked the Regional Centers to share this information with the Homes. We'll also be sending this out through the Key Contacts by email, and then in addition, providing the names of the contacts at each Regional Center that the Homes can reach out to work with on this. So Kristal, I think I'm going to transition back to you.

Kristal Vardaman:

Thanks, Jim. Next slide, please.

Kristal Vardaman:

On this slide, we have some tips for clean claim submissions. We've mentioned clean claims in previous webinars and just wanted to take a minute to reiterate that clean claims, or claims that can be processed without obtaining additional information from the service provider or from a third party, not including claims from a provider under

investigation or for fraud, abuse, or claims under review for medical necessity. Here on the slide, I won't read through every bullet in the interest of time, again, these will be posted, but hope you all can see these as a resource, these tips for submitting Clean claims, somewhat of a checklist to prepare claims for submission. Next slide, please.

Kristal Vardaman:

Similarly, we wanted to reiterate some tips and promising practices to help support billing and payment under the carve-in. Many ICF/DD Home providers are new to billing plans for services provided to members and will require support as they build their knowledge of MCPs submission protocols and clean claims requirements and plans should be working collaboratively with the Homes to ensure alignment and understanding claims requirements and the submission process. And again, some promising practices here for your review at a later time. The next slide, please.

Kristal Vardaman:

We've also mentioned LTSS Liaisons several times throughout the presentation and wanted to emphasize their role in supporting providers throughout the Carve-In transition. MCPs are required to identify an LTSS Liaison to be a single point of contact for service providers in the LTSS community. Liaisons can assist providers in addressing claims and payment inquiries and care transitions to support member needs. MCPs will share their LTSS Liaisons' contact information to their Network Providers and update providers on any changes to LTSS Liaison assignments. And if any ICF/DD Home providers have not yet been in contact with their LTSS Liaisons for those plans serving their counties, please reach out to the LTC Transition Inbox shown on the slide, and the team can provide you with their contact information.

Kristal Vardaman:

And with that, I'll hand it off to Stephanie from the Managed Care Operations Division to provide an update on member enrollment.

Stephanie Conde:

Hi, good afternoon, everyone. I'm Stephanie Conde from the Managed Care Operations Division. I'm going to provide just a brief update on the transition and where we are today. Next slide, please.

Stephanie Conde:

So current ICF/DD Home members were enrolled into a managed care plan based on the member's selection or their auto-assignment effective January 1, 2024. Members can expect to receive a welcome packet from their managed care plan this month in January. Members will also receive the Plan Identification Card from their managed care plan. Just as a reminder, members need to bring both their membership card from the managed care plan and their BIC, their Benefit Identification Card, when going to an appointment in order to receive services. As a reminder, if there's only one plan option

in the county, members may change their plan on a monthly basis by calling our Medi-Cal Health Care Options phone number or going to the website. On their customer service portal, they can also select a new plan. And next slide, please.

Stephanie Conde:

So we wanted to provide a quick update also on how providers can check a member's Medi-Cal eligibility and also their managed care plan, to help determine what managed care plan to bill. So providers can check AEVS. AEVS is our Automated Eligibility Verification System. It is a DHCS system. Providers can check if a member's assigned to a Delegated Subcontractor by checking the member's eligibility on their prime Contractor's provider portal. So AEVS, our Eligibility Verification System, will have the subcontractor listed, but also the provider can check if the member's in a subcontracted plan by checking the provider portal from the prime Contractor. And for example, in Los Angeles County where we do have our subcontracted managed care plans, a provider can check HealthNet as their prime Contractor provider portal to see if the member is enrolled in Molina. The provider can also confirm a subcontractor by checking the member's plan ID card. And we did provide a link to our subcontracted entities. It's in Appendix H in our Resource Guide. Next slide, please.

Stephanie Conde:

A few ways members can get support if they're having eligibility or enrollment issues. If members have questions on their Medi-Cal eligibility or need to update information in the Medi-Cal Eligibility Database, they need to contact their Local County Office. We did include a link here which lists the county offices and the contact information for each of those offices. If an ICF/DD member is not able to enroll into a managed care plan due to a mismatch in their address and county code in our DHCS Medi-Cal Eligibility Database, the member or the authorized representative needs to also contact the Local County Office. So a mismatch in our DHCS Database will prevent the member from enrolling in a plan, simply the member needs to just reach out to the county office and get that county mismatch updated in our database. As a reminder, these members will remain in Fee-for-Service until that address is updated.

Stephanie Conde:

In addition to an authorized representative or a local representative, these entities may act on the applicant's behalf for eligibility-related matters. Our 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's no spouse, conservator, guardian, or executor and the applicant is not considered competent. For managed care plan assistance, our members or representatives, including Regional Centers and ICF/DD Homes, may contact Medi-Cal Health Care Options for plan enrollment assistance. And the link is here for their number and website access.

Stephanie Conde:

And next slide, please. And I actually am going to turn it back over to Kristal. Thanks, Kristal.

Kristal Vardaman:

Great. Next, we will go through some stakeholder questions. I just want to talk over a few logistics before we begin the discussion period. First, DHCS and DDS are going to begin with some questions that were submitted in advance via the Zoom registration form or that didn't have a chance to get answered on past webinars. After that, we're going to go to questions from Office Hours attendees, although we're going to try to filter through which questions overlap. There's some overlap between the two groups of questions, so hopefully some of those attendee questions will be addressed earlier on.

Kristal Vardaman:

And so, to ensure that we cover as many questions as possible in the next 20 minutes, please submit your questions via the Zoom chat function. And if your question's chosen and you'd like to provide some more context or clarification, then please use the Raise Hand function and a team member will unmute your line.

Kristal Vardaman:

So with that, we'll go ahead starting off with some questions that were submitted prior to the call, starting off with some questions around contracting and credentialing. So these questions are for MCQMD, Dana and team, if you're available.

Kristal Vardaman:

The first question we've got here is, "If members choose an MCP or automatically assigned to an MCP that an ICF/DD Home provider does not have a contract with, what will happen?"

Dana Durham:

So if that has happened, we encourage you to reach out to the plan to begin conversations with that plan. We also encourage you to share a copy of the member's existing TAR to really ensure that seamless transition of coverage. The plans are working to make sure that no one is disrupted in their care and just want to make sure that communication happens as much as possible. So under the Continuity of Care, ICF/DD Home providers will be able to bill managed care plans and receive per diem rates while establishing a contract and undergoing credentialing.

Dana Durham:

However, you do need to submit the initial documentation that managed care plans requires, and it's listed in APL 23-023, to receive payments. That initial documentation

provides managed care plans with the relevant business information that they need to create their claims payment profile.

Kristal Vardaman:

Great, thanks, Dana. Another question around contracting credentialing. "For the credentialing process, does the MCP-specific provider training need to be completed by the ICF/DD Home provider for their initial credentialing at the time they're submitting the attestation form?"

Dana Durham:

That provider training needs to be completed within the first 30 days of the provider being contracted with the managed care plan.

Kristal Vardaman:

Next, I'm going to jump to some questions on enrollment, and I know we have one question in the chat with someone's hands raised that's, I think, also related.

Kristal Vardaman:

So one question from prior to the call, "Some members were enrolled in a different plan than the one they selected on their choice form. Why might that have happened?" I think this is a question for Stephanie.

Stephanie Conde:

Hi, thank you. There's a few reasons it may have happened, but one of the biggest reasons we see a member being default, even if they did choose a plan, was if they selected that plan after the submission deadline. So after that submission deadline in our systems, we are already queued up to default that member, and so the member will have defaulted prior to that choice being entered. And so what that means is the member will actually get into that plan choice the next month. So again, they have a choice monthly, it's just we have submission deadlines based on some system requirements.

Stephanie Conde:

I wanted to also say for members who have gotten into a subcontracted plan and maybe they didn't choose that plan, they sent in a choice form and they chose that prime plan, again, if they didn't get that choice form in by the deadline, they would have been defaulted without that prime contractor knowing that they chose a subcontractor. So in those circumstances where a member did choose the subcontracted plan, the member just needs to reach out to the plan and make that request. They can either reach out to the plan they were put in, so if they were put into the prime, they can reach out to their prime plan, and they can make that switch the subcontracted plan or they can reach out to their subcontracted plan that they're put in and make that request and

that subcontract plan member services will get them over to their right number to get them switched.

Kristal Vardaman:

Thanks, Stephanie.

Michelle Retke:

And then really quick, Kristal, if I can just jump in, going back to the first part of the question about a member possibly still being in Fee-for-Service during the month of January because possibly their choice hadn't been recorded for whatever reason or there's the county mismatch of information that I know was touched on before from eligibility concerns, if a person is in the Fee-for-Service Medi-Cal environment during January, then that means the provider would bill Fee-for-Service. And then when that person is then enrolled in the plan for February, just talking basic example, then the provider would then work with and bill the plan. So just kind of wanted to add that because that's been another piece that has come in as well.

Kristal Vardaman:

Thank you. And we have a question from Tetyana who's got her hand raised. The question that came in the chat was, "We have a few individuals who were enrolled in the wrong plan. They selected Health Net, but were enrolled in L.A. Care. We contacted Health Care Options and they're working on correcting the issue. In the meantime, do we now have to contract with the plan that the members were erroneously enrolled in until the issue is corrected? Which MCP is going to be responsible for payment?"

Kristal Vardaman:

I think this is a question for MCQMD, but Tetyana, you have your hand raised. Is there any additional context or information you'd like to give? Team, if you could unmute Tetyana, that'd be great.

Tetyana Wynter:

Yeah, thank you, Kristal. Yeah, no, that's my question. Do we now contract with L.A. Care just to get paid for that one month while Health Care Option is correcting the issue or who's responsible for the payment during this time?

Michelle Retke:

Wherever the member is... And Dana, I don't know if you and your team are going to jump in?

Dana Durham:

Sure. I don't mind answering. It's going to be the same answer that you had, which is wherever that member, wherever the resident is a member, is the plan that is to be billed for the month that they're a member of that plan. So not necessarily, Tetyana, do you need to come into contract with the plan, but you do need to have a conversation with their LTSS Liaison and make sure that you can bill them as an Out-of-Network provider for that month.

Tetyana Wynter:

Great, great. Good to know. Thank you so much.

Dana Durham:

Thanks for the question.

Kristal Vardaman:

Great. We have a few other questions that are around enrollment and billing issues. So one question... Let's see. One question here is, this is a pre-planned question, "What should ICF/DD Home providers do if their members' plans have not yet provided access to a member provider portal? How can Home providers track authorizations, claims, and payments?" I think this is for MCQMD actually.

Dana Durham:

So, can you say that again because I thought you said it was enrollment?

Kristal Vardaman:

Sorry. Yes, yep, yep. Sorry, this is about provider portals. It sounds like some plans have not yet provided access to a provider portal, and so how can Home providers track authorizations, claims, and repayments?

Dana Durham:

Yeah, and that's a really good question. Now, a provider portal is only going to be provided by most plans if you are already in contract with them. So there are various ways that the plans will work with you to bill if you've not completed that contracting process. And we met with plans that had not told us specifically when they had had provider training for Out-of-Network providers yesterday and made sure that either they give us the dates that they've had that training and/or that they schedule those dates and let the ICF/DD Homes know that. So, we expect for that training of how to bill if you're an Out-of-Network provider to be forthcoming if you haven't received it already, but you will not get that provider portal information, often until you are actually in contract with the plan.

Kristal Vardaman:

Thank you, Dana. Next question. Continuing on billing and payment, this is a question about, "How can providers verify whether they should bill a managed care plan or Medi-Cal Fee-for-Service?" I think this is a question for MCOD.

Stephanie Conde:

Hello, again. Yes, we did go over this in the slide, but providers can check our AEVS system, which is our Automated Eligibility Verification System, to see if the member is in Fee-for-Service or in our Medi-Cal Managed Care plan. In the case of a member being in a sub-plan, again, AEVS should recognize that sub-plan. We are enhancing AEVS right now in order to work through some of the issues with reporting that sub-plan. So it's in the interim, but always along with these updates in AEVS, a provider can check the prime plan's provider portal. So all the plans have a website, and if you go on the website, there's a tab at the top and it's a provider portal. The providers can check that provider portal because in the provider portal, it'll say if the members a part of the prime plan or the subcontracted plan.

Stephanie Conde:

And also on the slide deck earlier, the providers can check the members' health plan identification card. On that card, it will say if the member is in the prime plan or in the subcontracted delegated plan. Thank you.

Kristal Vardaman:

Great. Thank you. Dana, I think I have a couple questions coming up for you. In the interest of time, I'm taking a few questions from the chat and then we can go back to some of the pre-planned questions.

Kristal Vardaman:

So Joe Hari has a question for you, Dana. "Does Continuity of Care requirements apply to suppliers or vendors who provide supplies to the Home, such as durable medical equipment, medical supplies, personal care supplies and nutrition services or groceries?" And Joe, I see you have your hand raised. Hopefully the team can unmute you to provide some additional clarification if needed.

Joe Hari:

Hi, yes. Thank you so much. So I know there are these protections, Continuity of Care for the Homes themselves, but what about the suppliers and vendors? So does the health plan have the ability to say, "You can't provide any more to us," or are there any Continuity of Care protections for the supplier?

Dana Durham:

So often, some of those supplies are through our pharmacy, which that is not changing, that process is not changing. So that would enable the same supplier to continue to deliver those services. But when there's an authorization for a DME or a different supplier that comes through the managed care plan, the authorization for the specific equipment or need, such as if there's a need for a supplemental or for something else that may be covered by the plan, the plan can use a different vendor which is in their network.

Joe Hari:

Got it, got it. Okay, thank you.

Kristal Vardaman:

And we have a few questions coming in around authorization issues. So one question from Antonio Ranit, "Several TARs are about to expire this year. Are we going to resubmit authorizations like under the previous system?" There are a few questions, comments made.

Dana Durham:

Yeah, and Bambi answered some of these questions in the chat. If a TAR has expired, you will need to go through the process to submit a request to the managed care plan. And I'm wondering if you can go into that slide that talked about that, Kristal, that talked about the various forms that are required.

Dana Durham:

One thing I do want to note, if a plan does have a plan-specific form, it can only include the information that is on the form. It can't add more elements to it. So if you'll look at the form, the authorization in the last set of bullet points, if there is a plan-specific form for the Authorization Request, it can only include the same elements. So you shouldn't be submitting additional elements, but you will need to submit these forms.

Dana Durham:

And Matt, I see your hand's raised. Hopefully we can unmute you.

Matt Mouer:

Hi, yes. So I actually submitted a question. We informed our managed care plan that we had four expiring TARs and we wanted to submit our package to them and they basically said, "Oh, no, you don't need to do that. They're covered under Continuity of Care." And we said, "I don't think so. I don't think the TARs are approved under Continuity of Care, but I could be wrong about that." So I would love some clarification for that because we just don't want to have four folks that are unauthorized.

Dana Durham:

Yeah, and a great question, Matt. If you will submit that question to our Long-Term Care inbox with the specifics of the plan. I don't know enough to answer that question well. What I'll tell you is that I want to make sure that there is no disruption. So if an Authorization Request should be submitted, we certainly will ask that. Now, they may be offering Continuity of Care based on the information they have, so I'll need to do some follow-up to understand that a little bit better, but it's a really good question.

Dana Durham:

And can you have Matt come off mute one more time? I just want to make sure that that's what he needed.

Matt Mouer:

Yeah. I mean, I think again, one just expired on the 20th and we submitted something before that and then a couple are coming up soon, so we can certainly submit something to the question. But I think it's more-

Dana Durham:

Yeah. What we'll do, I will have one of my staff send you a secure email. It won't be coming from the inbox, but it will just be coming from one of my staff, Matt. And we'll send you an email so you can submit, send specific information, so we can follow up with that and are compliant with HIPAA. So let me just have my staff send you an email so we can get the details and follow up with specifics.

Matt Mouer:

Okay. My thing is that I’m assuming we’re not the only ones that it has occurred to.

Dana Durham:

And you may not be, but I have to understand what the problem is with the specifics and what the plan is saying to understand. If other individuals are having this issue, if you’ll send a request to the Long-Term Care Inbox, we’ll send you a secure email to which to respond.

Matt Mouer:

Happy to do that.

Dana Durham:

It's really a good point.

Kristal Vardaman:

So we've got a number of other questions coming into the chat. Dana, I think this is another one for you. It's around bed holds and leaves of absences. "Could you speak to," I'll just kind of summarize, "Could you speak to authorizations for LOAs and bed holds? Are the MCPs able to require authorizations for LOAs and bed holds?"

Dana Durham:

So, I do think that the managed care plans need to understand what the bed holds are and really have some purview over it. And I saw your question, it was interesting to me. And Becky, can you come off mute? Can we have Becky come off mute and explain what you would... I do think 73 authorization request is not good for you or for the plan, but just want to understand a little bit more about what your current process is, and really if there's a way that you can submit several authorizations at a time, just want to understand a little bit more about your perspective, Becky.

Becky Joseph:

Hi, can you hear me, Dana?

Dana Durham:

Yeah, thanks, Becky.

Becky Joseph:

Okay, great. Thanks. Yeah, with regard to the authorization process, we have been having weekly calls with our MCP and they did state to us that they need to give us a new authorization number for every bed hold, which that's perfectly fine and acceptable. That's what we have done in the past, very understandable for the bed holds. Because that indicates that the client was in the hospital and if they come back on the eighth day, you know, we should be okay. But then they further stated that every time they go on a Leave of Absence, they need to issue us a new authorization number to bill for that leave day. And my point was our clients have 73 leave days per year, many of which they utilize those days. Many of those may not also be congruently being used, like seven days at a time. A client may go on pass two or three times a week, different days. It just depends on the situation.

Becky Joseph:

So, for them to require us to have a new authorization, to call for a new authorization number, to bill for one leave day every single time it happens is just... It’s unreasonable to me. And in the past, our TAR covered those leave days, those 73 days, but I was told that’s the way our system is set up, that’s the way DHCS wants us to get authorizations, and that’s the way it is right now. It doesn’t seem a doable situation. You’re adding a lot of administrative time for someone to call every single... I have 120 clients, so if 60 of

them go out on pass over the weekend for one day, we have to call for all 60 new authorizations to bill those people.

Dana Durham:

Yeah, I hear what you're saying, Becky. I'm going to have to take that back and kind of have a different conversation. I mean, I think one of the questions I'd like you to consider is can you submit several, if there's predictability in it, can you submit several requests at a time? We just want to make sure that we do hold the plans to being able to explain leave days because part of our job is oversight of the plans. And so I am just trying to be creative and think through how we can do that, Becky, without you doing 73 for each person. So just would love you to think on that as well and how we can make sure that we do oversight well, but I'll follow up with you and have a conversation because it's a really good question.

Becky Joseph:

Okay. Yeah, no problem. Thanks, Dana.

Kristal Vardaman:

Great. Thank you, everyone. Really, thank you all for your engagement and participation today and all your questions. Unfortunately, we're running out of time, so I'm going to go ahead and go to our closing slides.

Kristal Vardaman:

As mentioned earlier, so there's some resources that we have for y'all to learn more about the Carve-In policy. As mentioned earlier, there's a series of resources on the website and we'd encourage you to check out the member information webpage as well, which has some additional information tailored for members. Next slide, please.

Kristal Vardaman:

And I know there were many questions we couldn't get to. If you have any questions or questions that weren't addressed today, please reach out to the inbox, LTCtransition@dhcs.ca.gov, and it will allow you to submit those and be connected to the right subject matter experts at DHCS to get those answers.

Kristal Vardaman:

Thanks again for attending. I appreciate all your time today. Take care. Thanks.