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 101 for ICF/DD Homes

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SPEAKERS

Kristal Vardaman
Bambi Cisneros
Caroline Castaneda
Salvador Tapia
Kathy Karins
Salim French
Adrian Arce

Kristal Vardaman:

We'll go ahead and get started. Good morning or good afternoon everyone, and thank you for joining us today. We hope all of you in Southern California fared well in the storm. And as a reminder, if you have colleagues who weren't able to make it today, this webinar will be recorded and the materials will be posted. Today's webinar is titled Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Carve-In 101 for ICF/DD Homes. This webinar is the second in a series about the Carve-In. And again, a recording of today's webinar, the PowerPoint slides, and the meeting materials will be available on the DHCS ICF/DD LTC Carve-In webpage and we'll be putting a link to that webpage in the Zoom chat. We're going to ask now that you add your organization to your Zoom name. In order to do that, if you click on the participant's icon at the bottom of the window, you can hover over your name on the participant's list and then select "Rename" from the dropdown menu. And then please enter your name and add your organization as you would like it to appear. Next slide please.

Kristal Vardaman:

We've had a few meeting management things to note before we begin. Again, this webinar is being recorded and will be posted to the Carve-In webpage. Participants are in listening only mode, but can be unmuted during the Q&A discussion. To participate in the Q&A discussion, please use the raise hand feature and our team will unmute you at the appropriate time. You can also use the chat feature to submit any questions. Feel free to type questions into the chat throughout the presentation, and our team will be monitoring them and asking some of those as well during the Q&A session. Next slide please.

Kristal Vardaman:

We're excited today to have some great presenters. We're going to start off hearing from Bambi Cisneros, who's the Assistant Deputy Director of Managed Care at DHCS. We also have Caroline Castaneda, Deputy Director of Waiver and Rates Division at the Department of Developmental Services. And then we've got some special guests from Community Health Group. We have Salvador Tapia, Behavioral Health Manager, Adrian Arce, who's the Director of Claims Administration, Salim French, who's the Director of Contracting. And then also Kathy Karins who's the Clinical Director of the San Diego Regional Center. And right now I'd like to hand it off to Bambi who's going to share today's agenda. Thank you.

Bambi Cisneros:

Thank you, Kristal. And hi, everyone. Good afternoon. Thank you for spending your afternoon with us. We have slated 90 minutes for today's discussion and topics. We have a lot to cover and we're really excited to share this information with you today. For this afternoon, what we would like to cover is background and information about the Intermediate Care Facility for the Developmentally Disabled Carve-In, or ICF/DD Carve-In, that's slated to occur January 1st, 2024. And then we'll go through some of the policy requirements that's going to be in effect when the coverage of ICF/DD services

transitions to managed care and talk about some of the implementation activities there. And then, as Kristal mentioned, we do have some guest presenters today from Community Health Group and the San Diego Regional Center, and they're going to be talking about how they're preparing for the Carve-In from their perspective and some of their promising practices there on how to work best together. And then finally, we'll have an opportunity for Q&A after these presentations and then we will wrap it up with next steps. And so that's what we will cover this afternoon.

Bambi Cisneros:

Thank you. We will begin with an overview of the Long-Term Care Carve-In. So we can go to the next slide please. Effective January 1st, 2024, all Medi-Cal Managed Care Plans will become responsible for the full long-term care benefit, which includes the following Developmentally Disabled Home types, the ICF/DD which is the Intermediate Care Facility for the Developmentally Disabled, the Intermediate Care Facility Habilitative or the ICF/DD-H, and then the ICF Nursing, so ICF/DD-N. And so what this means is that all Fee-for-Service Medi-Cal beneficiaries residing in one of these ICF/DD Home types will be mandatorily enrolled into a Medi-Cal Managed Care Plan for their Medi-Cal covered services. And one thing we did want to note is that ICF/DD-CN for Continuous Nursing care is not part of this Carve-In.

Bambi Cisneros:

You can go to the next slide please. In terms of our Carve-In goals, the ICF/DD Carve-In is part of CalAIM's Benefits Standardization Initiative, which is really intended to standardize benefits and coverage under managed care across the state. And really this is to improve the member experience and also alleviate provider burden when they have to work with different managed care plans. And so standardization of benefits really means that no matter which plan model type the member is in, they will receive the same benefits regardless of which county they live in. And so our utmost goal for the ICF/DD transition to managed care is for members not to experience any disruptions in access to care or services. And then we're also working with our managed care plans and we'll continue to do so on communicating the policies that we will be walking through today, including the importance of timely payment.

Bambi Cisneros:

And then we'll also talk about today about the existing infrastructure today, which includes the Regional Centers and then the ICF/DD Home Model for individuals with developmental disabilities. And then we will talk about preserving those same processes today, which includes Lanterman Act protections and the roles and responsibilities of Regional Centers. And we will go over that in more detail later this afternoon.

Bambi Cisneros:

We estimate that approximately 4,500 members will be impacted by the transition to managed care for ICF/DD members, which will occur for the non-COHS counties. And so those are the counties that are blue on this map. And so as we had talked about in

previous slides, starting on January 1st, 2024, the non-COHS counties or the non-County Organized Health System plans will be carving in this benefit from Fee-for-Service into their managed care plan, whereas they're covered in COHS counties today. I will turn it over next to Caroline from DDS to provide an overview of the Regional Centers role under the Carve-In.

Caroline Castaneda:

Thank you, Bambi. Let's see. We can go ahead and move to slide 10 please. Just in a nutshell, many of you are already familiar with Regional Centers and we just want to take a moment to show you how they are geographically divided, which is a little different than how county eligibility works in Medi-Cal. These are our 21 Regional Centers' catchment areas that serve over 400,000 individuals with developmental disabilities throughout California. And they provide lifelong services and supports to assist individuals to lead independent and productive lives in their chosen communities. Next slide, please.

Caroline Castaneda:

And under the ICF/DD Carve-In, as the slide indicates, Regional Centers are going to continue to do the intake and assessment, eligibility determination, case management, do individual program planning development, and purchase necessary services and supports through their vendor system for those people who are going to be moving into the Long-Term Care Carve-In. Mostly we want to emphasize that enrollment into a managed care plan doesn't change a member's relationship with their Regional Center. The Regional Center continues to support that person regardless of what plan they're enrolled with. And they'll continue to access Regional Center services and go through the IPP process that they do today. And I'll go ahead and hand it back to Bambi.

Bambi Cisneros:

Thank you so much. Next we will cover the key policy requirements and roles for the ICF/DD Homes and the Regional Centers in the next few slides. We can go to the next slide please. Starting on January 1st, all Medi-Cal Managed Care Plans will be responsible for authorizing and covering medically necessary ICF/DD services. It's important for you to know that the benefits and services provided under Fee-for-Service today will not change, only the payer will change from Fee-for-Service to the managed care plan. Over the last 10 months, we have been engaged in a Workgroup comprised of representatives from ICF/DD Homes, some Medi-Cal Managed Care Plans, Regional Centers and their trade associations to really help advise the developments of several policy documents that gives guidance on the transition to managed care.

Bambi Cisneros:

And these documents include the All Plan Letter, or APL, which is our guidance to our managed care plans. It's an extension of our contract and has the full force as the contract, as well as the Model Contract Language, which can be found on our dedicated ICF/DD Carve-In website. We have learned a lot through this process and we will be bringing to you, as well as other stakeholders, our learnings and where we landed on

the policy. And we'll also walk through several member scenarios to show what these policies mean for the roles of the ICF/DD Homes and Regional Centers in continuing to receive services under managed care, under the new ICF/DD coverage.

Bambi Cisneros:

Go to the next slide please. First we will talk about continuity of care. Members have the right to choose their living arrangement as required by the Lanterman Act. And so in alignment with this, the goal of the Carve-In is to really maintain the member's current living arrangement, which is with the ICF/DD Home as chosen by the member. And so we've established continuity of care requirements for managed care plans to ensure that the members' ICF/DD Homes for at least 12 months while the managed care plans work to bring the Homes in their network. And so we wanted to make sure that this protection is automatic and doesn't require any action from the member or the representatives. And so, again, going back to guiding principles of members really not having any disruption to their care is why we're requiring this automatic 12 month continuity of care protection to stay in their same Home.

Bambi Cisneros:

And if the ICF/DD Home still does not have a contract with a managed care plan after this initial 12 month continuity of care period, members and their representatives can request an additional 12 months, but that additional 12 months, they must raise their hand and make that request of the managed care plan. So the initial 12 months is automatic and then the additional 12 months is something that the member and the representative must initiate. Continuity of care provides access to covered services, and so there's continuity of care to the Home, which is automatic and the member will stay in their same Home. And there's also continuity of care to covered services, which some of these services may require a switch to the managed care plan's in-network service provider in some cases, but they'll still have access or continued access to those services. Those services include transportation, some facility services, and some professional and select ancillary services, and levels of care coordination. But again, we want to emphasize that it is not within the scope of the managed care plans to change these living arrangements unnecessarily.

Bambi Cisneros:

Go to the next slide please. Another requirement for the managed care plans is to have a Long-Term Services and Supports Liaison, or an LTSS Liaison. And we really see this individual as a single point of contact for service providers in the LTSS community. And so what we were looking for with the managed care plans, that they have someone assigned to be able to provide assistance who has knowledge of this population and can really provide that intended assistance with providers when it comes to addressing claims and payments, inquiries and in care transitions when it comes to supporting the members' needs. We had the managed care plan sharing their LTSS Liaisons' contact information with their network providers and also making sure that they're updating this list as any changes to LTSS Liaison assignments change.

Bambi Cisneros:

Next, let’s take a look at what the transition to managed care will look like for most Medi-Cal members currently living in an ICF/DD Home. In this first scenario, the ICF/DD Home where the member lives is currently paid for by Medi-Cal Fee-for-Service and will be transitioning to a managed care plan under the Carve-In. In accordance with the Lanterman Act, as we had talked about, the member gets to decide where they live and this member does want to continue to live in their current Home when the Home transitions into managed care. And so during the transition, the Regional Center will work with the member and the Home to assist them in the transition process. This member has already been assessed for diagnosis and the ICF/DD level of care requirements by the Regional Center.

Bambi Cisneros:

The member’s Home will then contract with the managed care plan and then the Department, so DHCS, will share the preexisting Fee-for-Service authorizations through a data transfer to the managed care plan. The Home will then work with the LTSS Liaison at the managed care plan as needed. And then turning to the role of the managed care plan, since the member has already received a diagnosis and the level of care requirements that have previously been assessed by the Regional Centers, the managed care plan will continue the authorization and begin payment to the ICF/DD Home. And then the managed care plan will now be responsible for paying for the member’s other Medi-Cal services such as physical therapy.

Bambi Cisneros:

Next slide please. In Medi-Cal Managed Care, managed care plans are required to do Utilization Management, which means that it is in their purview to approve or deny service authorizations. It's what managed care plans do. But in the case of ICF/DD Home services, managed care plans must accept the medical necessity determination that has already been made by the Regional Centers and their attending physicians. And I just want to really emphasize this point because this is a different process than what happens today in managed care by managed care plan. So just really wanted to make sure that we illustrate the importance of this point here. Managed care plans are then responsible for approving the authorizations for up to two years, which is in alignment with state regulation. And oftentimes the services that members receive in ICF/DD Homes don't change vastly.

Bambi Cisneros:

I think oftentimes two years is when that authorization is really valid for, but the regulation does allow for up to two years. But just wanted to flag for this group here about the kind of level of services, and there's just not a lot of changes there that plans can come to expect. And then managed care plans are also responsible for all other approved authorization requests for services outside of the per diem rate. And they're responsible for doing that for 90 days after enrollment in the plan or until the managed care plan can reassess the member. And then finally, managed care plans are required to turn around routine authorizations in five days. So after the members enrolled in the

members in the plan, those are the authorization timeframes that the managed care plans must adhere to. Go to the next slide please.

Bambi Cisneros:

Next we'll talk about the TAR, or the Treatment Authorization process. We had previously talked about Regional Centers making those eligibility determinations for ICF/DD Home services. And so they will submit a referral packet to the ICF/DD Home for review and then after receiving that referral packet and confirming bed availability and capacity, the ICF/DD Home will then complete and submit the documents required for authorization to the member's managed care plan. And so these documents that will be considered as an authorization to submit to the managed care plan include the form HS-231, which is the Certificate for Special Treatment Program Services form, the Long-Term Care TAR form 20-1, which is the Treatment Authorization Request, as well as the DHCS 6013A, which is the Medical Review Assessment form.

Bambi Cisneros:

And then just specific to ICF/DD-N Homes, they're also required to submit the member's Individual Service Plan. And so these are the documents that are considered to be the authorizations that the managed care plan will accept as it was determined by the Regional Center. And managed care plans must accept these forms as evidence that the Regional Centers made that determination that the member meets the ICF/DD Home level of care. And then a note here at the bottom that the managed care plans are not required to receive a copy of the member's individual plan, or IPP. We can go on to the next slide please.

Bambi Cisneros:

As Homes work to adjust their processes, and managed care plans as well, to accommodate the submission of the authorizations to the managed care plans, the Department of Health Care Services is prepared to help Homes who may inadvertently submit their TARs to DHCS Fee-for-Service which they're accustomed to doing today instead of to the member's managed care plan. And so one of our top goals is really to ensure that there's no delays in payment. So I think we're really doing our best to do as much of an outreach as possible so that ICF/DD Homes are aware of the changes that are going to be happening, that they will need to be sending their invoices and claims to the managed care plan starting Jan 1 2024. But of course I think sometimes it's hard to capture all of the communications. Again, one of our top goals is to ensure that we're really ensuring that broad communication and really doing all we can to alleviate any delays in payment.

Bambi Cisneros:

And so, to that end, the Clinical Assurance Division here at the Department, who is currently responsible for processing the TARs in Fee-for-Service, they've established processes for identifying these TARs that are submitted to them rather than the managed care plans after the transition. What they'll do is if they receive a TAR for members that are to be enrolled in a plan after January 1st, 2024, they will deny the

TAR and then notify the ICF/DD Home of the denial and then work with them. And then the DHCS staff will have some dedicated staff on board to help review the TARs received just to make sure that they're either needing to be determined because they're Fee-for-Service members or they need to be redirected to the plan. And then they'll work with the ICF/DD Homes on making sure that warm handoff occurs.

Bambi Cisneros:

And if providers do have questions regarding the TAR process, we provided a phone number here for providers to use. It's a telephone service center, it's an 800 number, and we're working on a process internally for how we might best coordinate between working with our managed care teams, our Clinical Assurance Division team, and then working with our plans and their LTSS Liaisons. So just wanted to make you aware of the process that's occurring when it comes to doing internal care coordination on these authorization requests. We can go onto the next slide please. Here we'll cover a scenario to review the roles of the Regional Centers, Homes, and the managed care plans for a member who will be entering an ICF/DD Home after January 1st. In this scenario, the member has chosen to move to an ICF/DD Home after a consultation with a conservator. The member and their conservator have contacted their Regional Center to request a move to an ICF/DD Home.

Bambi Cisneros:

So the Regional Center would then assess the member for the ICF/DD level of care requirements. The Regional Center then submits a referral packet to the ICF/DD Home for review. Then the ICF/DD Home would confirm bed availability and capacity to serve the member and then notify the Regional Center by phone, and usually this happens within 14 days, and then the Home would then send that authorization request to the managed care plan. And then after receiving the authorization request, the managed care plan will review the authorization for the member and then begin payment to the ICF/DD Home, once the member moves into the Home.

Bambi Cisneros:

Go to the next slide please. When it comes to leave of absence and bed holds policy, managed care plans are required to cover the stay when members transfer from an ICF/DD Home to any acute care hospital setting, post-acute care setting, or rehab facility, and then require a return back to the ICF/DD Home. Managed care plans are required to authorize up to 30 days... sorry, 73 days per calendar year for a leave of absence and up to seven days per hospitalization for a bed hold. The ICF/DD Homes are to notify the member, or their authorized representative, of their right to exercise a bed hold provision, and then members can return to the same ICF/DD Home following a leave of absence or bed hold, if that is their preference. And then if a member doesn't want to return back to their ICF/DD Home following that leave of absence or bed hold, the managed care plan is then responsible for providing care coordination and transition support. And we would expect that the managed care plan work with their Regional Center and their Home to assist the member in identifying another in-network Home.

Bambi Cisneros:

We can go onto the next slide please. And we can talk about the third scenario here. That explains the roles of the Regional Center, Home, and the managed care plans roles in supporting an ICF/DD member who is hospitalized. The member in an ICF/DD Home is sent to the hospital for treatment of an acute care need and the member's doctor issues a bed hold for seven days. After the doctor issues a physician order for a bed hold for seven days, the Regional Center is made aware of the member's hospitalization and monitors for any possible additional services that the member may need. The Home will hold the member's bed for seven days and will bill or invoice the managed care plan for the seven bed hold days. And then the Home will also notify the member's conservator of the right to the bed hold provision. The managed care plan then receives notification of the bed hold from the Home and then authorizes the payment for the hospitalization and the bed hold.

Bambi Cisneros:

Thank you. Managed care plans are also required to coordinate and work with Regional Centers when identifying services provided to members by the plans. The Regional Center service coordinator will continue to be the ICF/DD member's primary source for accessing services and resources as identified in their IPP, even beyond the Carve-In of ICF/DD services into managed care. One thing to point out is that managed care plans are required to have a Population Health Management program, which really means that they need to look at their population as a whole and risk stratify to determine their needs. And so this means that they need to ensure access to the full continuum of care, whatever the member needs, so the array of case management and care management services will really depend on the member's needs. And these can include basic Population Health Management, Transitional Care Services and care management. And so that is one of the managed care plan’s primary responsibilities.

Bambi Cisneros:

And then another item to point out here is that, separate from the ICF/DD Carve-In transition work, the Department is working on developing an MOU template, or a Memorandum of Understanding template that Regional Centers and managed care plans must have and execute. And so this MOU, there's an existing MOU today, but the Department is working on updating this to take in consideration the 2024 managed care contract requirements and have just there be more robust requirements for care coordination, data sharing for members, et cetera. And so this MOU really is the vehicle to outline these processes for how the managed care plans and Regional Centers will work together in a detailed way, including specifically their ICF/DD members.

Bambi Cisneros:

We can go on to the next slide please. Next we will cover billing and payment policies under the Carve-In. And as a plug, we'll go through some of these points now and just wanting to let you all know that we will also provide a deeper dive on billing and payment in a future webinar and we'll talk about that in later slides as well. As we mentioned earlier, services for ICF/DD when the Carve-In occurs won't change, but only

the payment source to managed care plans, that's the major change. And what this means is that providers rather than sending their claims to Fee-For-Service as it's done today, after January, the Medi-Cal managed care plans will be responsible for reimbursing ICF/DD Home services to providers.

Bambi Cisneros:

And we have a state directed payment policy in place. And so what that means is that in counties where ICF/DD services are newly transitioning to managed care, the plan must reimburse the ICF/DD Home providers the payment amount that would be paid for the per diem services in the Fee-for-Service delivery system. And then the ICF/DD Home service provider must accept that amount. So it's the same amount as in Fee-for-Service, it's covered in the per diem rate. And then there are some services that are provided outside that per diem rate and then those are not subject to the state directed payment policy and would be subject to whatever the plans and the provider agrees to per their contract, separate and apart from the state directed payment. When it comes to payment processes, managed care plans are required to have a process for ICF/DD Homes to submit electronic claims and receive payments electronically.

Bambi Cisneros:

But they also need to allow ICF/DD Homes to submit invoices if the Home is not able to submit electronic claims. And we have actually issued a Billing and Invoicing Guide. We sent one out for comment previously, we sent a revised version on Friday that outlines the minimum necessary elements for the invoicing process that would be considered proper payment. I would encourage you really to take a look at that and let us know any questions arising from that review. In terms of payment timelines, the requirement per the contract and statutes are that managed care plans pay at least 90% of all clean claims within 30 calendar days of the date it's received. And we are making clear with our managed care plans that Homes are used to a weekly or biweekly check rate today in Fee-for-Service, and so as such, we are highly encouraging managed care plans to pay claims and invoices in the same frequency in which they are received, whether electronic or paper claims.

Bambi Cisneros:

You'll see this in the All Plan Letter that went out on Friday. And what we mean by that is if the Home is submitting their claims or their invoices and it meets those kind of minimum necessary elements that we're asking the managed care plans to not hold off until the 30 days to play the claim. They just need to play the claim as long as it's clean and it meets those elements and the frequency in which they receive it, if they receive it weekly, they receive it biweekly and again it meets those requirements. We are highly encouraging plans to pay those claims and invoices in that same frequency. However, would still want to point out that managed care plans paying within the 30 days is still within their contractual and statutory rights. So I think this is an area I think we'll be working really closely with the managed care plans and the Homes just to make sure that the clean claims processes and timelines, et cetera, are really clear. So we need to make sure that we get this right.

Bambi Cisneros:

I think we can go on to the next segment and talk about how Homes and the Regional Centers can prepare to work with the plans and implement best practices when transitioning to managed care. Here we have a high level overview of what Homes and Regional Centers should be doing between now and January 1st to prepare for the transition of ICF/DD services to managed care. And so right now, managed care plans are working on building relationships with Regional Centers and Homes to ensure that they meet network readiness for when the Carve-In takes effect. And ICF/DD Homes should be focused on working with managed care plans and just by responding to their outreach and starting to build those relationships and learning about their contracting efforts.

Bambi Cisneros:

And since each plan may have different processes for how they may handle their portals and billing and payment, et cetera, we would want the Homes to also be working with managed care plans and participating in the trainings that we're having managed care plans offer and all of the different ways that we're having the managed care plans work with their providers to make sure that they're all on the same page with their protocols and processes. ICF/DD Homes should also review their internal workflows as well for billing and authorization requests so they can determine how they may need to be adjusted to account for how they would need to be coordinating with managed care plans. And then as far as Regional Centers are concerned, as we had talked about in earlier slides, Regional Centers would be focused on working with managed care plans and working on executing those MOUs, as well as determining how they will collaborate with managed care plans on care coordination.

Bambi Cisneros:

Move on to the next slide please. Establishing contracts, or in the case of Regional Centers, Memorandums of Understanding, or MOUs: these are important elements that will really set a solid foundation for a smooth transition to managed care coverage when the Carve-In occurs on January 1st. When it comes to contracting, managed care plans are required to incorporate standard terms and conditions from the Model Contract Language. And this is language that we have issued for draft previously and we issued again as a revision on Friday last week. And so managed care plans would be incorporating these standard terms and conditions into their own network provider agreements with the ICF/DD Homes. And the Model Contract Language really just helps to ensure that there's a consistent delivery of ICF/DD Home services across all of the Medi-Cal managed care plans.

Bambi Cisneros:

And it sets forth all of the different requirements that we have learned through the Workgroup and that you'll see in the All Plan Letter, or APL, language. Credentialing: when it comes to credentialing, we are still working with the managed care plans and the Workgroup to look at the credentialing process to streamline that process to the extent possible, we are cognizant that the ICF/DD Homes are providing documentation

to the Department of Public Health for licensing and also documentation to the Regional Centers for the Regional Center vendorization process.

Bambi Cisneros:

And so we're looking to streamline what they've already been submitting to these other entities to find a way that there's not any duplication there. And so we will be issuing additional guidance on the topic of credentialing at a later time. And again, just a quick blurb on MOUs, just that these are... MOUs are a managed care plan requirement for 2024, to have an MOU with the Regional Center. And so we will be working on releasing the final All Plan Letter along with the MOU template to support this MOU collaboration process in the fall of this year, so coming soon. And these MOUs are required to be executed by January 1st, 2024.

Bambi Cisneros:

Go on to the next slide please. Preparing for the transition, we've provided a few tips for ICF/DD Homes to consider as they begin to work with the managed care plans and there are additional tips in the appendix as well. And so just to start out, we do encourage the ICF/DD Homes to start working with their managed care plans that have reached out to them. And Homes will need to be working with the managed care plans as managed care plans are doing what they need to do in order to outreach to begin building relationships and just working towards getting ICF/DD Homes and bringing them in-network between now and January 1st. We do see that engagement between the Homes and the managed care plans is really critical to ensure a seamless transition for our Medi-Cal members.

Bambi Cisneros:

And as Homes work with managed care plans, I would also recommend that the Homes work with their managed care plans to find out who the managed care plans LTSS Liaison is and then ask for details about their authorization and billing processes. And so just to better understand how the plans work and what their requirements are, you can determine how you may need to address any of your internal workflows. And then if there are plans that you're interested in contracting with, we do also encourage ICF/DD Homes to reach out to the managed care plans if they haven't already reached out to you today.

Bambi Cisneros:

And then also just wanting to make sure folks on this call are familiar with the Model Contract Language so that you know what to expect when contracting with the managed care plans. And you'll see all the different kind of requirements between the managed care plan and the ICF/DD Homes contained in the contract provisions. And again, managed care plans can also include their own terms in their contracts to make it fit within the structure of their network provider agreement. But we do require that the Model Contract Language in its intent that captures all of these kind of key standardized provisions are intact in those contracts.

Bambi Cisneros:

Go to the next slide please. To help support Homes, Regional Centers and managed care plans in their ongoing preparation and planning efforts, DHCS and DDS will be releasing additional resources and we'll be hosting additional educational webinars and office hours. We also provided on the slide a link to our dedicated webpage where we will be posting all of these guidance documents and resources and information. So things such as the All Plan Letter, the Model Contract Language, will be posted there as well as there's some other policy documents that we're working through, those include FAQs as well as a policy guide that's forthcoming, and so when that's developed we will also be posting that on the webpage as well.

Bambi Cisneros:

And then the next slide just talks about the upcoming webinars that we have. Today is the ICF/DD Carve-In 101 for ICF/DD Homes. You'll see in September that we have office hours. In October we'll have Promising Practices. We have a topic dedicated on Billing and Payments in November. Another office hours in December. And then another session on supports for ICF/DD and Subacute residents in December. And so we are still working through what all of these will look like and how they will tack and tie, but just wanted to have you bookmark these dates and times. We do have our intended audience to be the managed care plans Homes in the Regional Centers, but they are open to the public, and so we do highly encourage you all to join to hear all of the different discussion topics.

Bambi Cisneros:

And then of course, we'll be reaching out in advance also when it comes to the office hours to see what questions the plans, the Homes, the Regional Centers, public in general have so that we can be sure to address them. And we'll spend some dedicated time walking through those questions at those office hours. And again, wanted to encourage you all to visit that ICF/DD Carve-In webpage. We are keeping that updated with additional updates and resources including all of the materials from the webinars. So just want to make sure you have that as well.

Bambi Cisneros:

And then, the next slide talks about member communications. The Department will be mailing member notices to members starting in November, and if the members also have an authorized representative on file within MEDS, those notices will also be mailed to those authorized representatives to make sure that the members are getting the notices that they need to receive. And then usually we have a Notice of Additional Information which accompanies the member notice. Doing something a little bit different this year, we're posting that on the website and are also going to have it be available through a QR code. And what the NOAI is, or Notice Of Additional Information, is really like a frequently asked questions format, which goes in a little bit more detail on what the changes are, what can the member expect, who can they contact if they have questions and things of that nature. And so, we'll be posting that on our website.

Bambi Cisneros:

We will also be working on posting a member facing version of the member notice. And so this one we are working with our ICF/DD Workgroup as well as with some consumer advocacy groups to make sure that it's reading in plain language. And so we are finalizing that. Again, we'll post that on our website, on our webpage that's posted here. And then lastly, just wanted to highlight that Health Care Options, which is a Department's enrollment broker. We'll also be doing a call campaign from November to January of 2024. We just want to make sure that we're getting the information out there as much as possible. And so we are doing what we can with member notices and posting things on the website, but also thought it would be good for phone calls. And that's what the member call campaign is going to do from HCO.

Bambi Cisneros:

And then lastly, we can cover post-transition monitoring and support, which we've talked about that there's going to be lots of different policies that we need to make sure happens as smoothly and as efficiently as possible. And this also means that the Department needs to have processes in place to monitor the transition, so that it is as seamless as we had intended for it to be. And so we wanted to briefly touch on a few ways that the Department will be monitoring the transition to make sure that there were not any disruptions in care for our ICF/DD members. For transitional monitoring, this is our standard process for how the Department monitors new benefits and transitions to populations after a transition to managed care. Typically, we have plans report certain cadences on certain topics or issues and they're related to things like continuity of care.

Bambi Cisneros:

We'd want to know the number of requests that they've been receiving, if they have been denying any, what the reasons for that might be. We'll be monitoring approval timeframes to make sure it's within those contractual and regulatory timeframes. We'll want to know about payments and any hiccups they're experiencing, what they're hearing from their providers and any workarounds or any technical assistance and training that they're doing with their providers to make sure that there is not any delays in payments. And we'll also want to know about networks and contracting, how that's going, who they're talking to, what feedback they're receiving from the field as they're going out and trying to establish relationships and just any member concerns and any other monitoring activities.

Bambi Cisneros:

We will start this out daily as we typically do, and then we'll taper it to monthly over the first quarter, and then quarterly, and that'll just be embedded as part of our quarterly monitoring process, as the members become part of the managed care delivery system. And then separate from the transitional monitoring, there's a quality monitoring and reporting processes. These are really about an ICF/DD quality assurance program that managed care plans must have and maintain. And so managed care plans in this regard, they're responsible for collecting this kind of data and information from the ICF/DD Homes and from the Regional Centers and then submit that to the Department.

Bambi Cisneros:

And so there's still some work happening in this space. We are actually going to be discussing that I believe at the October Workgroup meeting. We have our Quality and Population Health Management colleagues who working really diligently in this space to provide additional guidance. So I would say more to come in that space, but just wanted to give you a flavor of some of the things that the Department is going to be looking at to monitor this transition. And so with that, I think I will turn it over to you, Kristal.

Kristal Vardaman:

Yes, that's right. Thanks, Bambi.

Bambi Cisneros:

I have to drink some water.

Kristal Vardaman:

I understand. Thank you, Bambi. That was a lot of content that you covered. Thanks everyone for the questions. We've seen a number of questions coming in the chat. We also received questions in advance. People submitted some questions in the registration forms. So we've been behind the scenes trying to group some questions into themes, so please be patient with us, but we are trying to answer some questions in the chat, but also answer some questions live here. I've got a couple of questions I want to ask combined from the chat and the advanced questions, then maybe we can move to questions from people on the line and then go back and forth.

Kristal Vardaman:

Some of the themes that have come up repeatedly in the questions so far are issues around the continuity of care policy, issues around bed holds, issues around providers outside the ICF/DD, and also payment concerns, and also contracting. I'm going to take a couple of those before we turn it to the chat. Starting off with issues around continuity of care, there's a number of questions that have come in around that additional 12 months of continuity of care. Someone asked, "Would that be paid via Medi-Cal?" Someone else asked, "Could you talk a little bit about from which entity this request would be made, and whether the LTSS Liaison would be a part of that conversation?" So Bambi or someone else from DHCS, can you provide some input there?

Bambi Cisneros:

Yeah, happy to address those. Continuity of care are really just a certain set of protections for members so that they could essentially keep to the same services that they're receiving today or stay in the same Home that they're staying in today. The Department is going to be sharing data with managed care plans so that the managed care plans know who these members are and what their needs are. When we are talking about automatic continuity of care, that's what we're saying, we are going to give that data to the managed care plan so the managed care plan knows who the member is and the member doesn't need to take any further action on their part. The managed

care plan will then offer the continuity of care for the member to stay in their same Home while they're working with the Home to bring them in contract.

Bambi Cisneros:

And so that will be in place starting Jan 1, 2024. And then when it comes to services, I think this is the part where the managed care plan will be working with the Homes and the members, see what other services that the members need, because as I mentioned in previous slides, managed care plans are responsible for the full array of Medi-Cal covered services. Typically, managed care plans will provide those services in-network, so if they have a provider that's within their network to provide those services, they'll do that. But if members... If these services are not in the plans network, then the plans are required to cover that out of network no matter what. And so I think for this, I would just say that the managed care plans will be working really closely with members and the Homes and the Regional Centers just to make sure that they understand what the members' needs are, and we'll work really closely with the managed care plans as well, just to make sure that they understand that the data that we're providing to them and they see what services members need.

Kristal Vardaman:

Great. Thanks, Bambi. I think that answers some of the questions that came up around some of the, again, providers outside of the ICF/DD Home. So we will move on to some questions around bed holds. And we have a couple of questions, again, themes. One question was, "What happens after a seven-day bed hold and a client wants to come back to the same facility? Does the facility have to go through the process of readmission and reauthorization?" Another question about what happens, again, if the hospital stays longer than seven days, and will the MCP continue to pay for the hold of the bed, or will the Regional Center pick up payment for us to continue to hold the bed? So again, a number of questions have come in around bed holds.

Bambi Cisneros:

Sure. The bed holds and the leave of absence days are really just that those are the timelines in which the managed care plan will cover those services. And so if it's going to be longer than those timeframes, then the ICF/DD Home will need to submit a new request for those. Because the seven days is going to be the maximum timeframe. I'm seeing a question from Hanh. Thank you.

Kristal Vardaman:

Next we're going to turn to, I see a hand raise, Hanh, I think you should be unmuted, able to unmute.

Hanh Mireles:

Yes, I am. Thank you so much. I'm more concerned with our current number. We're ICF/DD-H in Kern County, so our managed care is Kern County Healthcare and Health Net. I did ask a question about how will they transition starting January 1st, and what plan will they be entering into? And then the question they responded was that they will

receive notice in November. The problem we have with our individuals is all of them are current Regional Center individual and they also have a third party payee. And sometimes we don't always know where the letters will be sent when it comes to Medi-Cal. I don't know if you guys have information on where the notification will be sent to.

Bambi Cisneros:

That's a good question, Hanh. I don't know if any of our MCOD team is on the line that can take that, but if not, then we can provide a detailed written response, Hanh, if that's okay with you.

Stephanie Conde:

Hi, Bambi, I'm on.

Bambi Cisneros:

Go ahead, Stephanie.

Stephanie Conde:

Sorry.

Bambi Cisneros:

No, go ahead.

Stephanie Conde:

Sorry about that. Hi, Hanh, this is Stephanie Conde from Managed Operations. The members will receive the notices, the address listed in MEDS, which is the address provided by the beneficiary, that's where the notice will go. But we are also sending it to the beneficiaries authorized representative that we also have in our database, so also in MEDS. So if a member has an authorized rep, that rep will also receive the notices. But the long-term care facilities will also have access to these notices, which will provide the link to the facilities as we get those posted, which we are targeting towards the end of this month.

Hanh Mireles:

Thank you. And then how would you guys send us an email with the link?

Stephanie Conde:

To the notices? We will be able to reach out... It will be an email, but the notices will be posted on the DHCS website. So anytime you're interested, or have questions because there's a Notice of Additional Information as well, you can access them on the DHCS website. But yes, we'll send an email with the link.

Hanh Mireles:

Thank you.

Kristal Vardaman:

Great. We'll take another call from the line and then we'll go back to maybe the pre-submitted questions. I see Rick, you have your hand up and you should be able to unmute.

Rick Hodgkins:

Can you hear me?

Kristal Vardaman:

Yes.

Bambi Cisneros:

Yes, loud and clear.

Rick Hodgkins:

All right. I am a client of the Regional Center that serves Sacramento and nine other counties. I am not in an Intermediate Home, but my question is, are you aware that we need to be careful of paying for duplication of services? Are you aware that we need to avoid duplications of services?

Bambi Cisneros:

Rick, you cut out a little bit. Would you mind repeating that again? I'm sorry.

Rick Hodgkins:

Because my phone was talking. Can you hear me?

Bambi Cisneros:

Yes.

Rick Hodgkins:

Are you aware that we need to avoid what is called duplications of services? And are you also aware that the Regional Center is usually the last payer... The last resort of payer... Last payer of resort?

Bambi Cisneros:

Yeah, I appreciate that comment, Rick. Agreed, that's one of our guiding principles as well, that's the reason why we've been working really closely with our DDS colleagues and the Regional Centers, the Homes and the Managed Care Plans to really make sure that we understand what's being covered by the Regional Centers that's separate and distinct from coverage by the plans.

Rick Hodgkins:

These are Group Homes, right? These are Group Homes, right? They're not facilities? Because we're moving away from institutionalization, other than with the Secure Treatment Program at Porterville and the Community Facility at Canyon Springs.

Bambi Cisneros:

The transition that we've been talking about is specific to the Intermediate Care Facilities, which are Homes. And so, they are residences where members live, not to be confused with the ones you had mentioned, but I'm happy to off why we you to better understand that facility. I don't know if that's an ICF/DD.

Rick Hodgkins:

The developmental centers were seen as ICF/DDs. That's all I have. Thank you.

Bambi Cisneros:

Thank you, Rick.

Kristal Vardaman:

Thank you, Rick. And just a reminder to everyone, we will drop in the chat, the inbox, the ICF/DD Transition, the inbox LTCTransition@dhcs.ca.gov. And if you have questions that you'd like a written response to that we aren't able to get to today, please send us an email. I'll take a couple more questions that came pre-submitted. I don't see any other hands up right now. Some of these may reinforce some comments that we've covered in some of the slides but are important to reiterate. Bambi, there's a couple of questions that have come in around the contracting process and when some of that should begin. Someone asked when will the MCPs contact us to start the contracting process? A number of people have asked questions around that contract language you mentioned. How do we know if the contract has been approved by the Departments? Someone asked how can we ensure the required language is in the contract? And just again, some questions about clarity on the process there.

Bambi Cisneros:

Sure. Thank you, Kristal. If the managed care plans haven't reached out already, they should be relatively soon, because we have asked them to start engaging with the ICF/DD Homes to start those relationships while we worked on the Model Contract Language. DHCS did issue the Model Contract Language on Friday. We will be posting it on our website. I think we're working on getting that posted now. There's some accessibility checks that need to happen. So that'll be posted on our website, so you'll see what those standard contract terms are.

Bambi Cisneros:

We're asking the plans to take those Model Contract terms and really embed that as part of their contract language. Now, understanding that they have their own network provider agreements and may not be able to lift and shift verbatim the language

because it has to fit within their contract structure. But in terms of the actual key policies and the intent of the policies, that's what we would expect for the managed care plan to integrate into their contracts between the managed care plan and the ICF/DD Homes. And so we are working on getting that up on our website. We did send that out, I believe by email on Friday, and so the link to the webpage that I had posted, that we had on the slides is where we will post all these materials.

Kristal Vardaman:

Great. Thanks, Bambi. And we have a couple hands up. I'll start with Susan. Susan Chau, you should be able to unmute.

Susan Chau:

Yes, our question is, how does the share of cost play into this change? Will it be directly to MCP or ICF?

Bambi Cisneros:

Kristal, I don't know if you -

Kristal Vardaman:

I think its, how share of cost plays into it, is that right?

Susan Chau:

Yes.

Bambi Cisneros:

Can you say a little bit more about the question? Is it just that whether the member will be in the plan or... I guess I'm not understanding the question.

Susan Chau:

The payment itself...

Susan Chau:

Something. Well [person coughing].[inaudible]

Kristal Vardaman:

I think we're having a bit of trouble hearing you, Susan. Maybe if you want to drop your question in the chat again, then we can circle back before we close out.

Susan Chau:

Okay.

Kristal Vardaman:

Let's see. How about Dominic, you've got your hand up.

Dominic Kingdamo:

Hi, Kristal. Thank you. And thanks, Bambi. This is similar to, or related to, the contracting questions, but specifically about credentialing. Are the MCPs able to use our existing credentialing documents already, and can we start credentialing with the ICF/DDs or do we need to still wait for additional guidance from DHCS? Thank you.

Bambi Cisneros:

Thank you for the question, Dominic. We are still working through what that streamlined credentialing policy looks like. Our intent is to have... To be able to leverage what the Homes are already submitting today to the various entities. And so just need to make sure that that's in line across all of our managed care plans and we need to issue guidance on that topic. I would say that's still in development and we're going to be issuing additional guidance on that topic.

Kristal Vardaman:

We're going to close out the folks who are on the line now. So I'll call on Larry, and then Les, and then we'll close on Susan's question before we move on to our guest presenters. So Larry, can you unmute yourself?

Larry Friedman:

Yes. Hi. Thank you. I just wanted to make sure I understand that if someone also has Medicare as their health plan, that Medicare will continue to be their primary medical plan and that the Managed Care health plan won't be taking over.

Bambi Cisneros:

Yeah, that's right, Larry. Yeah, that's right. If the member has Medicare and they have their primary care provider with Medicare, none of that changes with this Carve-In. They'll still continue to have those same Medicare services, have those same Medicare providers and wouldn't have any impact on Medicare in general.

Larry Friedman:

Great. Thank you.

Bambi Cisneros:

Of course.

Kristal Vardaman:

Thank you. Les, you can unmute yourself.

Les Parker:

All right. Thank you for taking my questions. I have two. One is going back to the bed hold. It was stated that it would only be approved for seven days. However, there are circumstances where our members might have procedures that may take them beyond the seven days. And in some cases when we know for certain they're coming back to

the facility, a bed hold extension might be granted. So are we saying that's no longer going to be the case? And then my second question is, we're currently being asked for our last survey, would our active license not suffice or are we expected to provide our last full survey document?

Bambi Cisneros:

On the first topic, Les, so the bed hold, those timeframes are within regulations. And so that just really means that's what the plan is going to be paying up to. We are looking to this experience to start building our data to see what the actual bed hold days would be, but would say that those days are just found in statutes and regulations. I think we need to a little bit more guidance in this area as we learn more and get more data. What I would say for now is just those are the timeframes that's within the provider manual and regulations as far as what the plan would be covering. And then I'm not sure I understand the question about the survey that you had mentioned. Would you mind saying a little bit more about what survey that is, who it's from? And if you can just -

Les Parker:

Sure. Every year we typically have an annual survey, a life safety and an annual survey from CDPH to maintain our license.

Bambi Cisneros:

I see.

Les Parker:

And we're being asked to provide our full survey results. Would our license, that we receive as a result of that, suffice or are we expected to provide the full survey to our MCPs for every facility?

Bambi Cisneros:

Les, thanks for clarifying that. I think that's the part where I said we need to have a little bit further discussions. Our intent is to be able to leverage what you've already been providing to CDPH to be able to leverage that. We understand that... Our goal is to alleviate provider burden to the extent possible, but we still have to finalize that policy. I think I would say more to come on that space, but the intent is to leverage what you're already doing.

Kristal Vardaman:

Great. Bambi, we're going to go back to Susan's question before we go to our guests. Her question was, how will the share of cost payment be affected by the change? Will the payment be directed to the ICF or will it be going to the MCP?

Bambi Cisneros:

I think I need to phone a friend when it comes to share of cost. I don't know if we have anyone on the call that could address that, but if not, we can respond in writing.

Stephanie Conde:

So members... Hi, Stephanie again. Members in long-term care aid codes with the share cost will be part of the managed care plan. Susan, does that answer your question?

Kristal Vardaman:

Susan, if that doesn't answer your question, feel free to send the inbox a question again, ltccarvein@dhcs.ca.gov, and we'll get you a written response.

Susan Chau:

To be clear, this is going to the MCP then?

Kristal Vardaman:

If there's another follow-up, I'll turn it back to Bambi to introduce our guests. I do see we have one hand and we can return to you, Matt, when we get to the next Q&A section.

Bambi Cisneros:

Great. Thank you so much and we'll have more opportunity to have dialogue at the end of this segment as well. I think next we will go through the best practices from Community Health Group and San Diego Regional Center. If I may turn it over to Salvador and Kathy, please take it away.

Salvador Tapia:

Thank you, Bambi. That was a wonderful presentation by the way. And my name is Salvador Tapia. I work for Community Health Group and I'm going to discuss the process San Diego's taking to address the Carve-In for the ICF/DD. And with me I have Kathy Karins. Kathy, do you want to introduce yourself?

Kathy Karins:

Good afternoon everybody. I'm Kathy Karins, Director of Clinical Services with the San Diego Regional Center.

Salvador Tapia:

Thank you. And can we move on to the next slide please? This is basically what we already discussed earlier, the three ICF/DD Homes that we pre-transitioning to Managed Care Plan benefits. Can we please go to the next slide? Kathy Karins, the reason we're presenting together, and me, is because we're the co-chairs of the San Diego Regional Center Workgroup and it's a Workgroup of all stakeholders for San Diego. We have all managed care plans, all six of them, them being Aetna, Blue Shield, CHG, Health Net, Kaiser and Molina. And we also have the Regional Center there of course, and we have Legal Aid which actually represents the consumer.

Salvador Tapia:

And we've been meeting for years now since the transition of ABA and we have a lot of experience working with each other. It's really nice that we all do everything the same, because it just benefits the consumer and it benefits all our providers, because we all work together and try to maintain everything the same as possible. I was looking at some of the questions everyone was providing earlier and they're discussing about the process, what it's going to look like. And luckily we've been working with ICF/DD providers recently. We've been authorizing month of and month after admission, so I feel that the process will be the same. It's going to be different because now we'll take over the benefit completely, but it's going to look very similar.

Salvador Tapia:

And just so everyone knows, the ICF/DD providers have been invited to this Workgroup since February 21st and they've attended. I see a lot of familiar faces here. I see Matt, Stacy, Jamie, it's nice to see all of you and I look forward to seeing you on November 21st, 2023 for our next meeting. Next slide please. This is Kathy's slide.

Kathy Karins:

Hi again everybody. We have been working with the Healthy San Diego group since 2014. That was when our ABA services moved over to the health plans, the managed care plans. We want you to know that our Community Services Department is available to meet with the ICF/DD providers for assistance with any specific issues. We are also participating in a statewide group between the Department of Developmental Services, Department of Health Care Services and the managed care plans as this moves along. And we're inching closer to the finish there in January of 2024. And training is being developed. It has been developed and you saw the dates that were given earlier for ICF/DD providers, Regional Center staff and managed care plan staff by the statewide group. So stay tuned. And back to you, Sal.

Salvador Tapia:

Right. And before we move on, I just want to discuss the tool that we share with ICF/DD providers and between the health plans and the Regional Center. It's a two pager, but it's all on one page and it has contacts for the liaisons with the health plans, the Regional Center liaison, which is Kathy, and then Legal Aid is there as well. So we've been sharing it with all our ICF/DD providers so they know who to contact for any questions about what it's going to look like for the MCP or authorizations for the current process, which is authorizing month of and month after admission.

Salvador Tapia:

We also in the back of that card have the process and what it looks like. And once we'll take over the benefit, in November we'll be discussing the change. We'll be disclosing the process in the back of that contact card so it will be updated. We're currently updating it to add the direct person for authorizations once we get the Carve-In. So more to see there. And if you can move on to the next slide please. I'm going to introduce my team, that way everyone can see who they are and get to know them in

person. I have Salim French, my Director of Contracting. Can you please turn on your camera, Salim?

Salim French:

Yeah, my camera's on. Good afternoon. I'm the Director of Contracting for Community Health Group. I've been in this role for a little over two years and I'm really excited about the opportunity of working with all of the ICF/DDs. Thank you.

Salvador Tapia:

And just to add a little bit to Salim, we've been meeting with ICF/DD providers also internally, just Community Health Group, to discuss claims and everything. And now, if you can move on to the next slide please, I'm going to introduce the person behind me, which is Adrian Arce.

Adrian Arce:

Hi, my name is Adrian Arce. I'm the Director of Claims here at Community Health Group. I know that this change could be a little bit scary, but I want you guys to know that we want this to be as easy as possible for you. We believe in a very hands-on approach when it comes to training. So we have a lot of experience in training providers who have little to no experience in billing electronic claims. Prior to the implementation, as the contract moves along, we will be working with your teams to get you set up to bill electronically. We'll teach you how to do it where it's very efficient for you, very easy. If by any chance, by the implementation date, for whatever reason you couldn't bill electronically, we'll accept invoices and we will share examples of what a claim with all the minimum elements needed for you, for your reference so that you can bill invoices if that needs to happen.

Adrian Arce:

Post implementation, we'll be meeting with all the Homes on a one-on-one basis to discuss any challenges that you might have, any successes and iron out any issues that may arise, whether it be claims, payment authorizations and whatnot. Because we want this to be as easy as possible. Like Bambi mentioned, this process is... All it's going to be is a payer change. That's it. And so we want that to be as smooth as possible. We're here to help. So if you have any questions, you can always reach out to us. And if you have any ideas or suggestions, stuff that you want to see in trainings, let us know.

Salvador Tapia:

Thank you. Next slide please. And this is the authorization process, it's what I touched on earlier, which is we're currently authorizing ICF/DDs for when they need to leave the Managed Care Plan to go into a Fee-for-Service Medi-Cal. And the authorizations process will continue the same to not make any changes. It'll still go through my department, which is the Behavioral Health Department. I have our number right there, which is the 1-800 number toll-free and also our fax number where you could submit your request to.

Salvador Tapia:

And if anyone that operates in San Diego County, would like to join the collaborative that hasn't joined the collaborative yet, please call that 1-800 number to connect with me, ask for Salvador and I'll send you the invite so you can be part of the collaboration. And hopefully this transition's very smooth, which I've been harping on it forever since the beginning of the year. Because I feel it's very important to make sure that this transition goes as smoothly as possible because this is the most vulnerable population and this is their Homes and we're treating it as such. Next slide please. All right, any questions?

Kristal Vardaman:

Hi, everyone. We've got some time reserved for questions for our guests. If you'd like to ask a question, please raise a hand. Let's say we'll start off with questions that are for Community Health Group and then if there's any other questions for the last few minutes, we can certainly try to handle a couple of those. But first, are there any questions either in the chat or if you want to raise your hand for our guests today and we'll take care of those first.

Salvador Tapia:

I saw a question about San Diego and yes, we're San Diego only.

Kristal Vardaman:

I don't necessarily see any other questions that are coming in, looking for any raised hands. Jamie, you have a question?

Jamie:

Can you hear me?

Kristal Vardaman:

You are breaking up a little bit. Can others hear? Perhaps you could drop your question in the chat and then that way we would be able to make sure we get to it.

Salvador Tapia:

Nice that you are here, Jamie, by the way.

Kristal Vardaman:

I don't see any other questions in the chat or any other hands raised. I'm going to give Jamie a moment to drop a question in the chat.

Salim French:

I think I see a question in the chat stating, "So is Community Health Group a managed care specific to San Diego area?" And the answer is yes, we are a managed care only in San Diego County.

Kristal Vardaman:

Great.

Salvador Tapia:

Any of the health plans, want to see our contact card that we shared within in San Diego and want to look at it and use it as a template, you can feel free to reach out to me as well and I'd be glad to share that with you.

Kristal Vardaman:

Jamie did drop a question in the chat, what clearing house would we use to bill electronically or would we just upload to the CHG portal?

Adrian Arce:

Hi, Jamie, I'll take that question. We work with a variety of clearing houses. The easiest one to use is Office Ally, that's the one that will be working with the Homes.

Kristal Vardaman:

Great. Any other questions for our guests? Jamie says, "Thank you for that answer." If not, maybe Bambi can come back and we'll ask a few questions that have come in through the chat. And if there's anyone else that comes in with a question for CHD, we can ask those as well. Let's see. For DHCS, Bambi or others, one question or one theme of questions that came up that we haven't quite gotten to today is around payment issues and a question about will rates of reimbursement be impacted in any way? We talked a little bit about payment in the slides, but there's more to come in upcoming webinars, but wanted to touch on that.

Bambi Cisneros:

Sorry about the... Say that again, Kristal. What are the-

Kristal Vardaman:

Will rates of reimbursement be impacted in any way?

Bambi Cisneros:

No, I think just that, not rates per se, but just the directed payment policy, which is that that managed care plans are required to pay the equivalent of Fee-for-Service rates for the services that are part of the per diem. And then things outside of the per diem are then subject to negotiation between the plan and the provider. But outside of that, we're not dictating rates aside from the state directed payment policy.

Kristal Vardaman:

I know there was... Go ahead.

Bambi Cisneros:

Sorry. It looks like people are liking the CHG portal. And so, I think this is why we were encouraging the Homes to work with their managed care plans, because they all have different portals and so I think these are all really great questions you'd want to ask the managed care plan that's working in your county, what theirs looks like and what kind of requirements they need and things like that. I think it's great. I think this is why this information sharing is so helpful and then just to have the conversation and build relationship, so thank you.

Kristal Vardaman:

Great. I know before we went back to, or before we started the second segment with CHG, there was a question, I believe a Matt had his hand raised. If you wanted to come back and ask the question, please do, as we are going to close out on this portion of the Q&A in a few minutes. And there's a number of questions, while we wait, asking about what plans are in different counties and I believe we're dropping that list in the chat as well as a resource.

Bambi Cisneros:

Thank you.

Kristal Vardaman:

I see a hand raised from Brian. Brian, you can unmute.

Brian:

Yes, can you hear me?

Kristal Vardaman:

Yes.

Brian:

I'm not sure if this is the right venue for the question, but I've heard some rumblings from other care providers that when it comes to placing clients with the MCO, you have CCLs and ICF that are basically similar models. CCLs are funded and paid for by the Regional Centers, from what I understand. And what the fear is, is that the MCOs are going to say, "No, no, we are going to deny placing the client in the ICF, let's place him in a similar level CCL." Because then the Regional Center will pick up the tab instead of the MCO. So is there any truth to this idea that the MCOs are going to say, "We don't want to place the client here because then we have to pick up the tab." You see what I'm saying?

Bambi Cisneros:

Kind of, Brian. I think I'll start to answer and then I'll see if our DDS colleagues want to later on. But I think this is why it was important for us to point out that the Regional Centers are the ones doing that medical necessity in determining level of care. And then

the managed care plan is then responsible for authorizations and payment for those services, because we understand that the Regional Centers are who is looking at the members' needs for ICF/DDs, ensuring that level of care determination. And so we wanted to preserve that process to let that stand. I don't know, if maybe Caroline, if you may have anything to add to that piece?

Caroline Castaneda:

I would just add that yes, that those decisions about where someone lives are still going to go through the IPP team and would be driven by the IPP team.

Brian:

Can you still hear me or no?

Caroline Castaneda:

Yep.

Brian:

Are the authorizations just going to be automatically approved if the Regional Center says, "I want client A to live in this ICF"? Will they be automatically approved, or is the MCO going to review and say, "Well, we think they should be placed somewhere else."

Bambi Cisneros:

The Regional Center will make that determination. It's going to be on those same forms that the Homes and providers are used to doing today when they're sending it to Fee-for-Service. And what we were just highlighting in today's discussion is that we're really trying to preserve that process to the extent possible. And so the Regional Centers, doing that determination, using the same forms, and if that's provided to the managed care plans and it's completed, filled out, signed by the Regional Center's attending physician, the Regional Center's determination will stand and the plans will be required to continue authorizations for that. So hopefully that helps.

Kristal Vardaman:

We've got a few hands raised, so I'm going to go ahead and ask people to-

Brian:

Thank you.

Kristal Vardaman:

... go through those starting with, I'm sorry if I get your name wrong, Matija?

Matija Cale:

Yes, thank you. It's Matija. I think you answered, Bambi, thank you, I think you answered my first question about the authorization process. So it sounds like we're just doing the administrative piece from the managed care plan and the Regional Center is

doing all the determinations, so we're just actually creating the authorization and doing the approval or denial letter based on the recommendation. Is that correct?

Bambi Cisneros:

Yes, yes, that's correct.

Matija Cale:

And then my second question has to do with the data we received from DHCS in order to provide the authorizations for continuity of care. The data we received in the phase one of long-term care was very challenging and our analysts had a lot of challenges to try to help decipher it to make it make sense for us to easily create authorizations. So I was wondering if we're going to get cleaner data that's just very simplistic so that we can create authorizations based on that.

Bambi Cisneros:

Of course. And appreciate the question. And we did hear about some of those challenges as well, which we're seeking to resolve for this transition. I'm actually going to see if any of our MCOD partners are still on the line. I know they've been liaising with our data team to get the data needs, so I just want to see if they have anything that they could share at this time. But I think at a high level I'll say that we are working on getting the most complete and accurate data and it's going to of course depend on the claims and how complete that was then. But I think when it comes to clarity of data fields and what that means, I think those are things that we can work on. But let me see if our MCOD team is on the line, potentially could add a little bit more there.

Matija Cale:

Thank you.

Stephanie Conde:

Hi, again, it's Stephanie Conde. The data, to Bambi's point, the TAR information that we supply to the plans is only as good as we get it submitted. But to address the complexity of the data fields, it's the same way the plans get the all-payer claims monthly data, which went through a really big update a couple of years ago for the plans to get exactly what they need. I would like to offline a little bit more to understand the question because those are the current fields you get today for your currently enrolled members. And so that's how we are providing it for those members who are incoming for the Long-Term Care transition.

Matija Cale:

Thank you. I'd love for myself and somebody from my analytics team to give some feedback on that because we want to make sure that this is a smooth transition and that we are just automatically authorizing services. We weren't able to do that with the first Carve-In due to the data that we were getting it, we couldn't read it in order to be able to make easy authorizations. So if there's somehow you can give me your contact information, I'd love to be able to provide that information.

Stephanie Conde:

If the Aurrera Health Group team can just provide that, that would be great, and happy to work with you, or honestly to connect you with some more technical folks within the Department and we can get those clarified so it's useful. Thank you.

Matija Cale:

Great, thank you.

Kristal Vardaman:

Great, thanks. A few more questions and a few more minutes. I'm going to go to Barbara next. Barbara, you can unmute yourself.

Barbara:

There you are. We good?

Kristal Vardaman:

Yes, we hear you.

Barbara:

I'm from San Joaquin County and I work with VMRC. And this is not for San Diego, but it is about crossing county lines. We don't have a lot of great services here in San Joaquin County. We have to go for our oral surgery up in Sacramento, we have to go down to Fresno, I'm not sure what county that is for some of our dentistry needs. We have to go up to UC Davis for some of our neurological and kidney issues and cancer issues. Do we have to do a continuity of care for when we have to cross county lines or do we go with an insurance company that's bigger that will not just be stuck in San Joaquin County?

Bambi Cisneros:

Barbara, thank you for your question. We are encouraging our plans to really contract even outside of their counties for that reason as well to really have as much a robust network as possible. But we do understand it is member choice as to where they live and what plan they choose. And so there's all those factors at play. I am aware of some of the access challenges in San Joaquin and we'd be happy to work with you on whatever concerns that you have specifically, but would say that we are asking the plans to really reach out and work with as many ICF/DD Homes as possible to bring them in network for the same reasons that you mentioned. Just want to make sure that there's a robust network in place.

Bambi Cisneros:

But happy to work with you. And actually it's a good probably segue for the... I saw that we started dropping the long-term care transition inbox, email inbox address for this group because we want to let you know that we are taking down all these questions, and as we are working on developing additional guidance such as the form of FAQs, I

think this will help us focus our responses and some of these more frequently asked questions, and can also respond in writing for some of the detailed questions that have come in as well. So just wanted to mention that.

Kristal Vardaman:

And Bambi, I think we're starting to close out on time. So Robin and Susan, I apologize we hadn't had a chance to get to you, but if you please send your question to the inbox, we will provide responses in writing. And I will first thank our guests from Community Health Group and the San Diego Regional Center for their comments today and then turn it over to Bambi to close us out with some final remarks.

Bambi Cisneros:

Great. Thank you. Again, just really wanted to say thank you and appreciate all of the comments, the feedback, the discussion. It's clearly evident that there's a lot of interest in this topic. It's really important that we get this right. The Department has been working really closely with the Workgroup, the Homes, the Regional Centers, our DDS partners, and we still have a lot to go working towards a transition. So thank you for all your questions. I'll really take that into advisement on how we might issue additional guidance out in the field. I do want to show the slide where we have the webpage that we're posting all of our materials, we are keeping that up to date, and as things are being developed, we are posting them to our website, so we do encourage you to take a look there, as well as all of the upcoming office hours and educational training series that we have teed up.

Bambi Cisneros:

And again, also wanted to leave the email address on the next slide. This is our email inbox that we're using for all of the Long-Term Care transitions, including ICF/DD. And so we are monitoring this daily. We're going to be responsive to all of your inquiries and needs. So please send your questions in and we will be responsive. And again, I think on behalf of everyone here, from the Department, DDS and all of our colleagues on the line, just want to thank you for your time and appreciate your participation. Thank you so much.