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SPEAKERS

Kristin Mendoza-Nguyen
Bambi Cisneros
Emily Woolford

Kristin Mendoza-Nguyen:

Good afternoon, everybody. Give everyone a couple of minutes to come in from the waiting room. Thank you for joining today's session for the CalAIM Intermediate Care Facility for the Developmentally Disabled ICF/DD Carve-In Office Hours. This session is part of an educational webinar series about the ICF/DD Carve-In.

Kristin Mendoza-Nguyen:

A recording of today's session, the slides, and the meeting materials will be available on the DHCS ICF/DD LTC Carve-In webpage. You can find the link in the webpage in the Zoom chat momentarily. Next slide.

Kristin Mendoza-Nguyen:

All right. So just to kind of quick logistics, how to add your organization to your Zoom name. We ask that you take a minute to update your name in Zoom so it appears with your organization. It helps us track questions if we need to follow up with participants. You can go ahead and click on the participants icon at the bottom of the window, hover over your name in the participants list and select rename. And you can enter your organization as you would like it to appear. Next slide.

Kristin Mendoza-Nguyen:

A couple housekeeping items for the office hours. Again, this session is being recorded. The materials will be posted on the webpage. Participants are in listen only mode right now, but they can be unmuted during the Q and A discussion if needed to provide any context or clarity for questions submitted in the chat. To participate in discussion, please use the raise the hand feature and our team will unmute you. Feel free to use the chat feature throughout the presentation. We'll be tracking them and then queuing them up for the Q and A after this presentation. Next slide.

Kristin Mendoza-Nguyen:

Here's the agenda for today. We'll start off with a brief overview of some key policy requirements and promising practices. And then following that we'll have an opportunity to discuss stakeholder questions. We will kick off the Q and A period addressing some questions that we did receive in advance of today's session, or that have been recently submitted to the LTC Transition inbox before we open it up for questions from all attendees. And then finally we'll wrap up with next steps.

Kristin Mendoza-Nguyen:

And with that I will transition it over to Bambi Cisneros, the Assistant Deputy Director of Health Care Delivery Systems, to kick us off with an update on the ICF/DD Carve-In.

Bambi Cisneros:

Great. Thank you so much, Kristen. And thank you everyone for your time and joining us this afternoon for our office hours. So, for this afternoon, we're going to go over the key policy requirements of the ICF/DD Carve-In and some promising practices. And of

course, leave some room for a discussion and Q and A from you all. So, we can go to the next slide please.

Bambi Cisneros:

Okay. And we can next slide as well. Okay, great. Thank you. So here are some stats on the ICF/DD Homes transition. So, you'll see here that DHCS had identified approximately 4,000 members to transition from Fee-for-Service to a managed care plan across 31 counties on January 1st. And approximately 95% of these members transitioned on January 1st. And so, you'll hear that it's not 100% and it's because we have found that there were certain situations where the individual was pending plan enrollment status, which prevented them from being enrolled in a managed care plan on January 1st.

Bambi Cisneros:

So, some examples of that could be that a member may have a mismatch in between their county and their address, in which case that change needed to have been reflected in MEDS. Or a member chose a plan after the cutoff date on their choice form. And then the plan selection will then have taken place after the following month.

Bambi Cisneros:

And so, if you are a provider in this scenario and see that the plan enrollment is not yet effective in AEVS when you confirm plan enrollment, please do continue to bill Fee-for-Service. We did send out an email blast and newsflash announcement to make sure the providers are aware of this. We can go to the next slide please.

Bambi Cisneros:

And so, on this slide here, we provided a link to the ICF/DD Carve-In webpage where we have various information and resources housed, which are listed here. And I won't read them all to you, but one of the highlights we wanted to point out is a new resource, which is a letter that was addressed to the managed care plans on Continuity of Care Protections for ICF/DD Home members.

Bambi Cisneros:

And so, this letter which was issued to all of our managed care plans, really just reinforces the Continuity of Care policies and requirements that must be honored for members that were residing in an ICF/DD Home that have newly transitioned from Fee-for-Service to Medi-Cal managed care.

Bambi Cisneros:

And so, although it was intended for managed care plans, we also wanted to post them here. It's helpful information as you work with plans, providers, and members, and the public at large on the Continuity of Care policies.

Bambi Cisneros:

We are also working on releasing an updated version of the FAQs later this week. And we are also providing here a link to what we're calling the Resource Round-Up. And so, if you want more context and descriptions of all of the available resources and any updates that have been updated since their original release, you can find that description here in the Resource Round-Up, which is also linked here on the slide and on our webpage.

Bambi Cisneros:

Okay. Go to the next slide please. Thank you. Okay, so now we'll touch on some key policies and some promising practices to support implementation. With respect to Continuity of Care, managed care plans are to automatically provide 12 months of Continuity of Care for the ICF/DD Home placement for all members that are residing in a Home that was then undergoing the mandatory transition into a managed care plan after January 1.

Bambi Cisneros:

And so, what this means is that managed care plans were instructed to use the data provided by the Department to then offer those Continuity of Care arrangements without the member having to raise their hand. Continuity of Care protections also extends to providers such as primary care providers, specialists. And other ancillary providers such as physical therapists and occupational therapists.

Bambi Cisneros:

But unlike the Continuity of Care provision for placement in the Home, members do need to request Continuity of Care to the providers. And they can request that up to 12 months if they have a preexisting relationship with that provider.

Bambi Cisneros:

And then when it comes to Durable Medical Equipment, or DME, and medical supplies, there are also Continuity of Care protections there. And the policy in this case is that managed care plans are to allow members to keep their existing DME rentals and medical supplies from their existing provider that was under their previous prior authorization.

Bambi Cisneros:

And plans are to honor that for a minimum of 90 days following enrollment to a plan. Then after 90 days, the managed care plan can then assess the needs and transition the services to an in-network provider for the member to then continue getting the DME and supplies.

Bambi Cisneros:

And then there's of course other services that can also get continuity to that service but may require the member to change to a provider in the plans network. And so, these

include facility services, professional services, some ancillary, and transportation and care coordination. So, this means that Continuity of Care will provide continued access to that covered service, but it may require a switch to an in-network plan provider.

Bambi Cisneros:

Go to the next slide please. And in terms of promising practices for Continuity of Care, as I had mentioned earlier, DHCS did share data with the Homes, with the plans. Shared data with the plans to use for Continuity of Care with the Homes. However, the data that DHCS shares with plans may experience a data lag.

Bambi Cisneros:

And also, if there was missing information on the TAR file, for example, managed care plans could request additional information on members with those existing TARs to just ensure that they can process and approve that authorization for members. And so, because of that, we do encourage Homes to share their members' TARs with the managed care plan just to ensure kind of that direct data sharing there.

Bambi Cisneros:

And then for other services, ICF/DD Home providers can share information with plans on other service providers that are currently serving ICF/DD members. And so, in this way, managed care plans can work to bring those providers in network if they are not already in network.

Bambi Cisneros:

And then to then help facilitate continued member access to services and supplies, managed care plans should also share their in-network providers with all of the Homes where the members reside. And so, this just ensures that managed care plans have visibility and awareness of who the Homes have been working with.

Bambi Cisneros:

We understand these are longstanding relationships using these providers. And it would be most advantageous for the members if those providers that the Homes have been working with and the managed care plan can also work together. And so that is the reason for the data sharing there. Can we go to the next slide please?

Bambi Cisneros:

Okay. So here talking about a Leave of Absence and Bed Holds. Managed care plans are required to cover Leaves of Absences or Bed Holds that a Home provides. And this really is established in state regulations in terms of the LOA and Bed Hold policies. And so those regulations state that the authorization for Bed Holds can be authorized up to seven days. And usually, Bed Holds are used when a member is admitted to an acute care hospital.

Bambi Cisneros:

The other requirement is for Leaves of Absences. And so, the requirement here is that plans are required to authorize up to 73 days per calendar year for a Leave of Absence. And those Leaves of Absences can be used to do visits with relatives or friends, as well as participating in organized summer camps for individuals with developmental disabilities. And then members may return to the same ICF/DD Home following that Leave of Absence or Bed Hold if that is the member's preference because member choice is paramount here.

Bambi Cisneros:

So Regional Centers, the Homes, and the managed care plans are then encouraged to regularly communicate regarding any changes in a member status during a Leave of Absence or Bed Holds. And they should work together to ensure that a member's needs are met before, during, and after a Leave of Absence or Bed Hold. Okay, go to the next slide please.

Bambi Cisneros:

Okay. So now we'll discuss requirements for plans when it comes to billing and payment. In terms of payment processes, plans must have a process for Homes to submit electronic claims and receive those payments electronically. But if Homes are not able to submit electronic claims, plans must also allow for an invoicing process for Homes to be able to submit those invoices to the managed care plans for payment.

Bambi Cisneros:

And 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. And that applies whether it's submitted electronically or via paper claims. And ultimately, plans must pay claims or portions of claims as soon as practicable, but no later than 30 calendar days after receipt of the claim. And so that's the contractual and All Plan Letter policy for plans.

Bambi Cisneros:

Some promising practices for billing and payment processes includes for providers to check which clearinghouses that managed care plans are using for those electronic claim submissions. And then also see if managed care plans will cover the costs associated with any of those clearinghouses. Our understanding is some plans are offering low or no cost clearinghouses and so would be good for providers to ask plans what support they can offer there.

Bambi Cisneros:

And then likewise, shorter payment timeframes for clean claims can also support the ICF/DD Homes when making the transition to managed care. And so, we're aware that managed care plans are looking at these ICF/DD claims carefully, and some plans are actually even putting them in a separate queue just to make sure that nothing is missed.

And so, know that plans are working on really trying to shorten these payment timeframes to the extent possible.

Bambi Cisneros:

And then one piece here we would like to highlight is that if a Home is experiencing cashflow challenges or anticipating that there would be cash flow challenges, we do encourage you to reach out to the managed care plan and work with them to mitigate those challenges. In our conversations with the managed care plans, they don't want the Homes to experience those either and are willing and open to discuss those. So just be openly sharing where you are with that. And the next slide please. Thank you.

Bambi Cisneros:

Okay, so changing gears a little bit to talk about the local code and claim form conversion. So, as you all are likely tracking effective February 1st, DHCS transitioned to a HIPAA-compliant code set and national claim form for Medi-Cal Fee-for-Service. And really this was done to comply with national standards and helps with administrative simplification.

Bambi Cisneros:

And so, what this conversion included is the replacement of the local codes when it comes to the accommodation codes as well as a combination of the NUBC revenue codes, value codes, and value code amounts. And this conversion also entailed replacing the local payment request for long-term care or LTC 25-1 claim form within National UB-04 claim form.

Bambi Cisneros:

And just wanted to note here that this code conversion applies to Medi-Cal Fee-for-Service. And when billing for services that are provided to members in a managed care plan, ICF/DD Home should work with the managed care plan to ensure that the appropriate codes are being utilized. Our understanding is that many plans have actually converted to the UB-04 prior to February 1st and have already kind of worked on making these system changes. And so, we would have Homes work with the managed care plan just to see where they are with these codes that are being utilized. And then the next slide please.

Bambi Cisneros:

And so here for provider training and support, we wanted to reiterate the training and supports that managed care plans are required to provide to ICF/DD Home providers. So, one piece here is the LTSS Liaison who is to serve as the managed care plan single point of contact for the Homes, in both a provider representative and care coordination representative role.

Bambi Cisneros:

And so, one of the things we're finding as we're a little bit further down after a post-transition, is that the LTSS Liaisons, although they do serve as that point of contact at

the plan, because many of these kind of policies that we've even talked to today, they're cross-functional, and they may hit different areas of the plan. So, for example, contracting and credentialing, it could be the claims department, et cetera. And so, the LTSS Liaisons may not be able to address every question that the provider has.

Bambi Cisneros:

But our communication with the plan is that in this role, the LTSS Liaison should be an escalation point and can provide a warm handoff for those ICF/DD Home providers. To then transfer to other planned staff who can address their specific questions or needs across those functional areas.

Bambi Cisneros:

And additionally, managed care plans must provide training to providers on their billing protocols including how to submit claims and invoices. We understand that plans are using different clearinghouses and have different provider portals. And so, we do understand and acknowledge that providers, this could be a learning curve. And so, we would ask that plans to really provide that training to the ICF/DD Home providers as they learn how to work with each other.

Bambi Cisneros:

Managed care plans must also ensure that providers have access to the information they need to support this access to care. And so, this means that plans do use provider portals and so we would need plans to be able to provide the ICF/DD Home providers with the status of their claims, referrals, and authorizations so that they are aware of where that is in the process.

Bambi Cisneros:

And while providers are undergoing contracting and credentialing with managed care plans at this point in time, some may not be contracted with the managed care plan. But regardless, they should still have access to the portal or other types of access where they can see the status of their claims, referrals, and authorizations.

Bambi Cisneros:

And so really want to make sure that plans ensure that providers have access to this information through portals and other mechanisms. It is important for the Homes to be able to see this information.

Bambi Cisneros:

Okay. And I think with that I will turn it over to Department of Developmental Services to discuss the Regional Centers and their payment assistance program.

Emily Woolford:

Yes, thank you so much, Bambi. So as this slide states, DDS has recently issued updated guidance on the Regional Center lag funding. The purpose of this is to accelerate the availability of temporary payment assistance for ICF/DD Homes.

Emily Woolford:

Now in order to receive lag funding, the provider must attest that the Home has submitted claims to an MCP and has not been reimbursed after 30 days. Or that due to factors beyond the provider's control, they've been unable to submit claims or been delayed in the submission of claims to the MCP for services provided at least 30 days prior to the request. This is the newly added piece.

Emily Woolford:

Also, as noted here on this slide, Regional Centers will issue payment within 10 working days. And also wanted to mention that the Lag Funding Directive, updated guidance, agreement, and attestation form are available on the DDS website and we're happy to place those links in the chat shortly.

Emily Woolford:

And finally, we want to note that ICF/DD Homes can contact their Regional Center with questions about lag funding. Folks can also reach out to DDS at the health facilities address there on the slide with questions as well. And now I'll go ahead and hand it over to Kristen to kick off the Q and A portion.

Kristin Mendoza-Nguyen:

Great, thank you, Emily. And thank you, Bambi. So next slide, I'll turn it to the questions that were submitted in advance. So, the first question is about Letters of Agreement, “Some MCPs ask ICF/DD Home providers to sign Letters of Agreement while they work to establish a contract. What is a Letter of Agreement?” And, Bambi, I think this is for you.

Bambi Cisneros:

Great. Okay. Thank you, Kristen. Yes. So, a Letter of Agreement. You may hear it be called different types of other contracts. It could also be referred to as a Continuity of Care or a Single Case Agreement. And what this is, is it's used by plans to establish a Continuity of Care relationship with a non-contracted provider.

Bambi Cisneros:

So, while the managed care plan is working to bring the ICF/DD Home provider into their network, they may have the provider sign this kind of LOA or Continuity of Care Agreement. Managed care plans use this Letter of Agreement to demonstrate that the plan is delegating member services to the ICF/DD Home provider, or other service providers while they work to establish a contract with the provider.

Bambi Cisneros:

And one thing we'll point out is that while all managed care plans and ICF/DD Homes should be working to establish a contract, a Letter of Agreement can help facilitate billing and payment while a contracting process is underway.

Kristin Mendoza-Nguyen:

Next slide please. The next question is about authorizations, “So, if an ICF/DD Home member's treatment authorization request is expiring soon, what is the process for reauthorizing ICF/DD Home Services?” And, Bambi, this one's for you.

Bambi Cisneros:

Sure. So managed care plans are responsible for approving authorization and reauthorization requests for their members. And so ICF/DD Homes will need to submit certain documents to the plans for reauthorization requests.

Bambi Cisneros:

And so, this includes the Certificate for Special Treatment Program Services form or the HS-231, the ICF/DD Authorization Request form, which is like a plan specific form. Which greatly mirrors the Fee-for-Service TAR form. The 6013A form, which is the Medical Review Prolonged Care Assessment form. And for the ICF/DD-N Homes only, the Individual Service Plan. But again, that applies only for the ICF/DD-N Homes.

Bambi Cisneros:

And then during the initial transition, some managed care plans we found have opted to extend the existing TARs. So, they're extending the TAR dates and we have found that extending those existing TARs should not affect the provider's claim submission for timely payments. That's something that we were working with managed care plans.

Bambi Cisneros:

Again, we do encourage the Homes to contact the managed care plans to verify their processes for handling expiring TARs. Because some plans are extending on the date while others are creating new authorizations.

Kristin Mendoza-Nguyen:

The next question is on LOAs or Bed Holds. “Are MCPs required to have the same process for requesting a Leave of Absence or Bed Holds? Do all MCPs require prior authorization?”

Bambi Cisneros:

Yeah. The plans having the same process for requesting LOAs or Bed Holds have to do with plans needing to have a Utilization Management process. And that UM process is really to help support the receipt, the review, and approval or denial of authorizations for Leaves of Absence and Bed Holds.

Bambi Cisneros:

Some plans may require prior authorization for Leaves of Absence and Bed Holds, but what I would say is the Department is reviewing how plans are operationalizing the LOA days. Sounds like maybe some plans are requiring an authorization for each time that the member exercises the Leave of Absence at any point during that 73 calendar days.

Bambi Cisneros:

And what I would say here is that really it is not the intent of the Department or the managed care plans to make this notification process a burdensome process for providers. So, we would have the Homes work closely with the managed care plans Utilization Management staff or the LTSS Liaison, to make sure that there's just the appropriate notification.

Bambi Cisneros:

So, I think the distinction we're making here is that it would be a notification because plans do need awareness of the member situation since we do hold the plans responsible for coordinating the member's care and working with the Regional Center and the ICF/DD Home. And so, it just is a level of notification and awareness that the managed care plans need to have.

Kristin Mendoza-Nguyen:

Next question. Next question is for our Managed Care Operations Division, "How can an ICF/DD Home provider determine who to bill for ICF/DD Home Services?" I think if, Stephanie, you're on the line.

Stephanie Conde:

Hi, good afternoon. Sorry I could not get off mute. Hi, Stephanie Conde with Managed Care Operations Division. Bambi spoke to some of this earlier in the presentation, but just as a reminder, our providers should be using the automated eligibility verification system. We call that AEVS to check for a member's eligibility. We have included the link for easy access.

Stephanie Conde:

The member's Medi-Cal eligibility record will identify which managed care plan the member is enrolled in or indicate if that member is in Medi-Cal Fee-for-Service. If a member is enrolled in a delegate plan, the provider should be checking the prime plan's eligibility portal. And we included some information on here that's only applicable in Los Angeles County.

Stephanie Conde:

And just as one quick reminder again, Bambi did present on this. In AEVS, it will indicate if the member is in Medi-Cal Fee-for-Service, the provider should bill Medi-Cal Fee-for-Service. Thank you.

Kristin Mendoza-Nguyen:

Thank you, Stephanie. All right. Our last question that was pre-submitted is about member service and provider networks. “Can ICF/DD Home members receive services from existing providers even if they are not in the MCP's network?” For Bambi. Bambi?

Bambi Cisneros:

Oh, sorry. Sorry about that. So, this question is about the ICF/DD Home members receiving services from existing providers? Yeah. Okay.

Bambi Cisneros:

So, the member, their authorized representative, or provider may request that the 12 months of Continuity of Care with a provider if there is a pre-existing relationship with that provider. And these protections do extend to provider types, certain provider types. So, these include primary care provider, specialists, and some ancillary providers which include physical therapy and occupational therapy, respiratory therapy, behavioral health treatment providers, and speech therapy providers.

Bambi Cisneros:

And then there are other services that are covered under Continuity of Care. But as we discussed earlier, may require members to switch to an in-network provider that the plan is contracted with. And those include facility services, professional services, and other ancillary services as well as transportation and care coordination.

Kristin Mendoza-Nguyen:

Great, thank you. Okay, so we're going to transition to our open Q and A. Just some logistics. To ensure that we can cover as many questions as possible, please submit your questions in the chat. We've already received some, so we're going to go through those.

Kristin Mendoza-Nguyen:

If your question is chosen and you'd like to provide more context or clarification, please do use the raise the hand feature. And we'd like to also note that DHCS may need additional member level details to respond to certain questions. So, if that happens, we'll please ask that you submit the necessary items to the secure email box at PCU Research.

Kristin Mendoza-Nguyen:

So, with that, I'm going to pivot us to the questions that we've received. So, the first question that we received early on from Ookie Voong, Hope House Incorporated, was regarding DMEs or medical supplies. “For incontinence supplies, how can we get reimbursement for supplies that providers have had to purchase out of pocket because shipments were stopped? Catchment Regional Center is reimbursing, but other Regional Centers are not supporting. Who and how do we ask to receive reimbursement?”

Bambi Cisneros:

Yeah, Ookie, I would say if the member in your Home is a managed care plan member, then you would work with your managed care plan. And if you need that information, we can drop in the chat. We do have the contacts for plans by county and so we can share that as well.

Kristin Mendoza-Nguyen:

Great, thank you. And then there was a question from Amber Cox. “What information is the ISP giving the MCP?” When you submit for TAR authorization to Medi-Cal, they do not require ISP to be sent to them, nor have we ever sent one. Bambi?

Bambi Cisneros:

The ISP information to the managed care plan. Yeah, so I think in terms of the plan’s obligations for care coordination, that's something that we look to the plans to do. And just to make sure that they're aware of what the member's needs are so they can coordinate those services. My understanding is that that was also a practice that was conducted in Fee-for-Service as well prior to this transition.

Kristin Mendoza-Nguyen:

Thank you. And there's a couple of questions in the chat from some folks about Regional Center payment assistance. So maybe a few questions, Emily, for you on the DDS side. Could you share who providers might be able to reach out to if they're having questions or concerns regarding the timeliness of lag funding?

Emily Woolford:

Absolutely. Please send an email to the Health Facilities inbox. I will place that in the chat.

Kristin Mendoza-Nguyen:

Great, thank you.

Emily Woolford:

Thank you.

Kristin Mendoza-Nguyen:

And there was one question, Emily, from Marilyn Bennett. “Should we have been able to get lag funding from San Gabriel Pomona Regional Center?”

Emily Woolford:

You know I can't speak to your situation in particular. So again, if you could send an email to the inbox, that would be great, and we'll circle back with you.

Kristin Mendoza-Nguyen:

Okay, great. Thank you. Let's see. I do see one hand raised. Rick Hodgkins, did you have a question? The team can unmute you.

Rick Hodgkins:

Yes, I have two questions. The first is a question I have, can those in, I mean I live on my own, knock on wood, in my own apartment. And I represent Capital People First, which is an organization that's a self-advocacy organization run by and for the IDD and the City and County of Sacramento.

Rick Hodgkins:

To the best of our knowledge, nobody in any of the People First chapters lives in an ICF/DD that we know of. But my two questions are this, can people residing in the ICF/DD Homes go to work? Or go to a work program for that matter if they're well enough?

Rick Hodgkins:

And somebody earlier had a question about incontinence supplies. Now I don't know if that question was answered because I'm on my phone and cause I couldn't get on my computer and I had a phone call come in and I had to answer it. They were wondering about since they have to pay for incontinence supplies out of pocket, they've been having to pay for incontinent supplies out of pocket because of shipment costs. Wonder if that question was answered?

Bambi Cisneros:

Yeah. Hi, Rick. Bambi Cisneros with DHCS. And so, in terms of your first question about ICF/DD members and their eligibility to do a work program, so DHCS does not dictate that. So, I think what we're talking about here as part of the transition, is that these numbers were residing in an ICF/DD Home that was, and they were currently eligible for Medi-Cal through Fee-for-Service delivery system. And then after January, and now a plan.

Rick Hodgkins:

I know that.

Bambi Cisneros:

So that's out of scope of this transition. So that's what I would say on the first question. And the second, I think what we were saying here is that if the member is a plan member, then the provider should work with the managed care plan to get reimbursement for those because the plan does cover that in their Continuity of Care.

Rick Hodgkins:

Okay. Maybe my first question should have gone to DDS because I didn't know which one of you I should ask that question. I know that this transition is about transitioning

from Fee-for-Service to managed care. I just didn't know if members if clients in these Homes could work or not.

Bambi Cisneros:

Sure. I don't know. Maybe I'll turn to our DDS friends to see if that's something that we can answer. Or I don't know if we need to take that back.

Emily Woolford:

I think we might need to take that back. Thank you.

Kristin Mendoza-Nguyen:

Thank you, Rick. Thank you, team. There's a question from Carl King, “How do we handle a situation when the assigned PCP can't provide treatment in a timely manner?”

Bambi Cisneros:

Can we help this person unmute and give a little bit more context? I'd like to better hear the situation.

Kristin Mendoza-Nguyen:

Carl King, I think was the participant who had the question.

Carl King:

Okay, yes. We had a situation earlier in the week where one of our consumers was sick and our nurse recommended that he see a doctor. So, he needed treatment. However, we contacted the PCP, and they said that the soonest appointment was in one month. And so, he was sick that day, but they could not see him for one month.

Bambi Cisneros:

Yeah. Carl, when an ICF/DD resident is a managed care plan member, managed care plans, they are subject to timely access appointment standards. And so that means they need to get an appointment for a member within those standards. And so, I don’t know if you’ve been working with a managed care plan to see if they can find an alternate provider.

Bambi Cisneros:

Oftentimes what they’ll do is if you can’t see the PCP, they could offer like a physician extender, like a nurse practitioner or a physician assistant to try and get the member in sooner. If you’re really not getting access to services, I would like for you to send information over to the PCU Research inbox here that’s on the slide, to send via secured mail with the member CIN number and we can follow up. But really, I think the plans really do their best to try and find the provider so that the member can see someone timely.

Carl King:

So, the first person to start with would be the liaison for the plan?

Bambi Cisneros:

Yeah, they should. Or even telehealth. There are different ways they can try and get a member be seen like sooner. And so, I'm concerned if you're hearing that they're not getting access to services. And so, if that's the case, I mean we would have you work with the plan first. Because I think maybe just asking those follow up questions.

Bambi Cisneros:

And if you are not getting a response or feel like the member's not getting access to services, I would ask that if you please send the information into the inbox that's listed on the slide, and we can take a further look.

Carl King:

Thank you.

Bambi Cisneros:

Of course.

Kristin Mendoza-Nguyen:

Thank you, Carl. Thank you, Bambi. The next question is from Grace Kano. “Can you address the V card that Molina is using that carries a transaction fee?”

Bambi Cisneros:

Yeah, so we've been made aware that Molina does issue debit cards to providers as a form of payment. And it sounds like that may be a form of payment when there's information that they need from the provider to set up their ability to get EFT or just paper checks.

Bambi Cisneros:

We are working with Molina right now to better understand how a provider could potentially opt out, if maybe they were waiting for information that they haven't gotten, and the provider wants to convert to EFT or checks. So, we're working with Molina to better understand that, but we do know that that is not the only payment option they're offering.

Bambi Cisneros:

So, if you haven't already reached out to Molina to ask them, and I don't know if we have Molina on the call, please do work with them because that's not the only means of payment that they're offering. It sounds like it just is one option when they don't have all of the information from the providers.

Bambi Cisneros:

But again, we're working with them to make sure that this information is clear to providers. So, providers know if they were to submit the needed information that they can opt out and get their payments through other mechanisms. I don't know if you have Molina on the line, if they want to add a little bit more.

Kristin Mendoza-Nguyen:

Anyone from Molina just send a chat, we can unmute you, happens to be on. The next question is from Terry Ward, “We have ICF/DD and facilities in Orange County that have been under Cal Optima MCP for several years. Will the statewide change impact existing managed care plans like ours?” Dennis Mattson also responded Bambi in the chat, but I wanted to see if you had anything else you wanted to add to that one.

Bambi Cisneros:

I don't think I've seen the chat. What was the response? Sorry.

Kristin Mendoza-Nguyen:

Dennis just shared that the Cal Optima relationship remains the same.

Bambi Cisneros:

Yeah, Dennis. Yes. Yeah, they’re already a COHS plan who was covering these services, so there should be no changes for them. Thank you.

Kristin Mendoza-Nguyen:

Other questions from Lilly Daniel, “I had one claim paid by Health Net. I submitted the claim using my existing software. Health Net issued a paper check to the facility. However, that check has not been received. It's either been lost, stolen, or delivered to the wrong address. It will take Health Net 30 days to trace the check. Can DHCS require that MCPs expedite electronic deposits over businesses?”

Bambi Cisneros:

Yeah, I mean I think we're aware that the managed care plans are willing to work with the providers to get through this process. And so, you may have, I don’t know if you’ve already posed that question to Health Net. And they may be on the line as well, but I know they would be willing to work with you. So, I would ask that you work with HealthNet on that.

Bambi Cisneros:

DHCS can help liaise between the provider and the plan, but I think typically we would see the plans making other arrangements to help the providers out. But I think I saw Health Net on the line. I’m not sure if they want to add anything additional on this.

Kristin Mendoza-Nguyen:

If there any Health Net folks, feel free to raise your hand and the team can unmute you. There was a follow-up question on the V Card question from Molina from Grace Kano, Bambi. They did not ask for the card, but they were already applying for the EFT. So, they would like to see about getting reimbursed for the fees. Any additional guidance you can offer to Grace?

Bambi Cisneros:

Yeah, I think we are still working with Molina to better understand that process, but that is one of the questions that we had asked as well. So, if they're not on the line to be able to speak to that, we will circle back on that piece.

Kristin Mendoza-Nguyen:

Okay. All right. And payment question on claims from Claudia, "All of my medical Fee-for-Service claims for February were denied and when I called medical, they were unable to tell me why my claims were denied. I now know that it was due to the new billing code 0101. Were there any other changes to the billing that need to be done before we submit? I would like to ask before resubmitting again."

Dr. Hisham Rana:

Hi. This is Dr. Rana from DHCS. I'm from the part of the Department that oversees the Fee-for-Service fiscal intermediary. Claudia, I just sent you a message. If you could get me your contact information, I can have someone reach out.

Dr. Hisham Rana:

Links have been shared over the last several months and there are additional links for information published on the Fee-for-Service Medi-Cal website. Which goes through a whole host of details related to changes to the billing for dates of service on or after February 1 related to the code conversion.

Dr. Hisham Rana:

But what I'd like to do is I'd like to review the phone call that you placed to our call center because they should have been able to tell you why your claim's denied. So, I'd like to look into that and get someone to reach out to you.

Kristin Mendoza-Nguyen:

Thank you, Dr. Rana. All right. There was a contact from Molina that was dropped in the chat, so for those that didn't quite see that yet, there's an email address for a Molina representative to help follow up on items.

Kristin Mendoza-Nguyen:

Other questions from folks? I think we covered. I'm going to give people a couple of minutes. If anyone wants to raise their hand for questions, you're welcome to do so. Diane VanMaren, the team will unmute you.

Diane VanMaren:

Thank you. I just would note that it seems that a lot of these questions are all around payment and billing because those have been our key concerns from day one. There needs to be some direction from Health Care Services to make it adamantly clear to the plans and to the Homes about how we can do the electronic processing. These paper checks, paper remittances, are getting lost. They're not adequate. It's a mess. And we've been saying that for quite some time.

Diane VanMaren:

The other thing that needs to be checked here too, please, across all of the 24, 25 MCPs, is to make sure that the remittance information is adequate in order to track the payments because this needs to be done. You have DHCS Audits Division, and we have cost reporting. And all of this feeds into the process. And at the MCPs remittance advice information, which is different than what we have been receiving on Fee-for-Service. It's not adequate that our Homes cannot properly track the information.

Diane VanMaren:

And it causes confusion with the cost reports, which leads to our rates and also leads to audit exceptions. So, I would please urge DHCS to follow up on that and engage on what is included there. And to make sure that everyone is adamantly clear what is needed to obtain electronic access so that all of this can be brought up to 2023 instead of 1950. Thank you.

Bambi Cisneros:

Yeah, thank you, Diane. And I think Dennis had a similar comment in the chat, so we'll look further into those remittance advices. Thank you. Becky?

Becky Joseph:

Can you hear me?

Bambi Cisneros:

Yep. Now I'm not sure if you were talking previously, but yes, I can hear you now.

Becky Joseph:

Okay. I want to clarify about the payments. And on one of your slides earlier it said 30 calendar days. The APL specifically says 30 working days. We need to get that…I know it may seem small, but this is where we're hearing from the plans. They look at one part. And there is a part in the APL that talks about 30 calendar days, but that is not the payment to the ICF/DD Home per diem rate. That is to other practitioners that are working with us.

Becky Joseph:

The one that is the rate for us to be paid is on page 18, and it's very specific. It says working days. And we went through this in many of our meetings to get that very well

clarified, and I think the plans just need to know that. That it's 30 working days, not calendar days, unless I'm looking at it wrong.

Bambi Cisneros:

Yeah, we'll take a look at that again, Becky. I know that we did make that change in the APL, so we'll take a look at that further and clarify if needed.

Becky Joseph:

Thank you.

Bambi Cisneros:

Of course.

Kristen Mendoza-Nguyen:

All right. Dennis?

Dennis Mattson:

Thank you. Hey, Becky, I think that refers to retroactive payments, which is another concern. Because that paragraph implies on page 18 that we have to re-bill. So, the Department's going to have to look at that also.

Bambi Cisneros:

Yeah, Dennis, I think from the call that we had this morning and understanding what the need is from the providers to not have to resubmit all of the authorizations under the new rate. Yeah, understood. That's something that we'll need to work together with our financing team and issue guidance on.

Bambi Cisneros:

But now looking at, I think Becky said page 18 of the APL. Yes. So, it's the 30 working days is the adjustments, but the timeliness of the claims payment is 30 calendar days. But again, that's no later than. And we do know that plans are trying to make this a timeframe, make it even sooner than this timeframe.

Bambi Cisneros:

But again, I think what we had shared this morning is that we're working with plans on operationalization of these policies. And so, I think if there's further clarification that's needed to be provided here, then we'll go ahead and do that.

Dennis Mattson:

Thank you.

Bambi Cisneros:

Of course.

Kristin Mendoza-Nguyen:

Okay. There was one question that came in through the chat. This might be a question, Stephanie, for you from Ookie Voong, “Doctors are canceling appointments, citing insurance eligibility portals are inconsistent. They're asking for copies of new health insurance cards. There are delays in updating eligibility information. We are currently being resigned back to the MCP we initially enrolled in after involuntary reassignment in January. When will these cards be issued? This is concerning as we are still being held to meeting regulatory standards.”

Stephanie Conde:

Hi, Ookie, this is Stephanie. We've been working together back and forth, so if there are additional concerns, we just need the CINs for those members, the medical identification in that secure email to help. Again, we've been working back and forth, so you can just reply to the email, and we can assist if there's a need. But yeah, the member should have the medical cards within seven business days. So again, we can assist if they're not getting those timely.

Kristin Mendoza-Nguyen:

Great. Thank you. And thank you to partners at Molina for responding to some other questions that have come in. I'm not seeing that there are any questions in the chat. I guess the last call for any hands from folks. If there's anything else before I proceed with wrapping us up for today. Susan LaPadula

Susan LaPadula:

Hi, how are you?

Bambi Cisneros:

Hi, Susan.

Susan LaPadula:

Hi. Will we be having another office hours meeting next month?

Bambi Cisneros:

Yeah, we're working on extending that. I think, Kristen, maybe that's a good tie in to your next. So, I'll turn it to you.

Kristin Mendoza-Nguyen:

Yeah.

Bambi Cisneros:

Thank you, Bambi. Thank you, Kristen. Thank you.

Kristin Mendoza-Nguyen:

Sure. Next slide please. All right. So just some quick recap, some resources that we've mentioned earlier. Webpage is there. The upcoming next office hour is taking place March 22nd at 2:00 PM. The registration and the agenda will be posted online when it's available, but these materials from today will be available on the webpage as well. Next slide.

Kristin Mendoza-Nguyen:

If there were any additional questions that were not addressed during this webinar, please do reach out to us at LTCtransition@dhcs.ca.gov. We appreciate your attention and participation in this office hours. We look forward to seeing you guys again on March 22nd. Have a good rest of the day. Thank you for joining.

Bambi Cisneros:

Thanks, everyone.