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

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SPEAKERS

Kristin Mendoza-Nguyen
Dana Durham
Tracy Meeker
Mark Hansen
Ed Mariscal

Kristin Mendoza-Nguyen:
We have some great presenters with us today. We have Dana Durham, Chief of the Managed Care Quality and Monitor Division at DHCS; Tracy Meeker from Managed Care Quality and Monitoring Division at DHCS. And two panelists joining today: Ed Mariscal, Director of Public Programs & Long-Term Services & Supports from Health Net, and Mark Hansen, Administrator at the Rialto Post Acute in San Bernardino County. The materials today will be available on the CalAIM LTC Carve-In website and you can find those materials in the Zoom chat. All materials from previous webinars are already on the webpage. Next slide, please.

Kristin Mendoza-Nguyen:
For today, we'd like to ask you guys to just take a minute to add your organization to your Zoom name. It helps us track the questions. There's a little button under the ‘Participants’ icon where you can right click and ‘Rename’ and add your organization next to your name on the participant list. Next slide. And then lastly, just a couple of meeting management stuff for today. So this webinar is being recorded. Everyone is in listen-only mode but will be unmuted during the Q&A. We have a couple of Q&A opportunities today. However, we do encourage you all to use the chat feature throughout, and then you can use the ‘Raise hand’ feature during the Q&A. We will unmute for questions. And with that, I will transition it to Dana to walk us through the agenda and to get us started for today.

Dana Durham:
Thank you so much, Kristin. We are excited about you being here and really talking about the Long-Term Care Carve-In. This is the agenda. We'll do our welcome and introductions, which Kristin just did. Then we'll talk about the Long-Term Care Carve-In transition to give you a background and an overview. The Skilled Nursing Facility Carve-In Promising Practices, do an overview… Talk about the LTSS Liaison. We'll have a discussion and then we'll talk about promising practices, which will include Leave of Absence and Bed Holds. Then we'll have another discussion and then we’ll do next steps and prepare to close. With that, I'll ask you to go to the next slide. We are talking about the CalAIM, or California Advancing and Innovating Medi-Cal, Long-Term Care Carve-In. Next slide.

Dana Durham:
The goal of the carve-in is to make coverage of institutional Long-Term Care consistent across all counties and members. And so, starting January 2023, Medi-Cal managed care plans in all counties, -currently only in COHS are skilled nursing facilities carved in - but in all counties, the Long-Term Care benefit for the following types of facilities will be carved in. That's Skilled Nursing Facilities, including a distinct part or unit of a hospital. All Medi-Cal beneficiaries residing in long-term care facilities are mandatory to enroll in a managed care plan for their services. And so, starting in July 2023, we'll be carving in additional facility types. And those are intermediate care facilities, intermediate care facilities for the developmentally disabled, ICF/ DDs for habilitative, ICF/DDs nursing, subacute facilities, and pediatric subacute facilities. Next slide, please.

Dana Durham:
Managed care plans are contractually responsible for medically necessary long-term care services regardless of the length of stay in a facility. COHS counties, as I said a minute ago, currently have the long-term care full benefit carved in. The CCI counties, or Coordinated Care Initiative counties, have the long-term care benefit for most facilities other than the

ICF/DDs carved in. In COHS and CCI counties, managed care members requiring long-term stays at
nursing facilities continue to stay enrolled in their plan and don't transition to Fee-for-Service. Cal MediConnect plans and managed care plans are required to coordinate care and transitions of care for beneficiaries. And I'm going to have you go to the next slide, which is the chart. This chart really shows which are managed care plans and which are COHS plans as well as the county associated with them. I'm going to pause here just for a second so you can look at it, and then I'm going to ask you to go to the next slide.

Dana Durham:
This slide says that managed care plans are responsible for medically necessary services for two months currently in non-COHS, non-CCI counties. That is the month of a person's admission to a long-term care facility and the following month. After the second month, MCPs must disenroll the member into Medi- Cal Fee-for-Service. This is how it happens currently, not how it's happening in the future. So, that is until disenrollment is approved by DHCS. The managed care plan must provide all medically necessary covered services for the beneficiary. Managed care plans are also required to coordinate the beneficiary's transfer to the Medi-Cal Fee-for-Service program upon the effective date of disenrollment. Next slide, please. Here are the non-COHS/non-CCI counties. And as I said, I'll pause just for a second here as well. Okay, next slide.

Dana Durham:
And this shows you statewide... So the dark pink are the COHS counties where SNF services are currently carved in. The CCI counties are in the light pink. And the counties where skilled nursing facility services will be carved in starting in January of the coming year, so just around the corner, is in kind of a purple- ish blue. So, it's estimated that approximately 28,000 members residing in skilled nursing facilities will be carved into managed care. Dual eligible members represent the majority residing in SNFs that will be transitioning to managed care. Next slide, please. Now, we're just going to go over really quick, what is changing. All Medi-Cal only and dually eligible beneficiaries in Medi-Cal Fee-for-Service residing in a skilled nursing facility on January 1st, 2023 will be enrolled in a Medi-Cal managed care plan either January 1st, 2023, or February 1st, 2023. So, beneficiaries who enter a skilled nursing facility and would otherwise have been disenrolled – so, before January they would've been disenrolled - but now they're going to remain in managed care going forward and that includes most Medi-Cal beneficiaries. So, just to note a few, Medi-Cal only beneficiaries, dually eligible beneficiaries, Medi-Cal beneficiaries with other health coverage, or OHC as we call it, including private coverage, and Share of Cost Medi-Cal beneficiaries in long-term care aid codes.

Dana Durham:
And so, why are we doing this? Well, it's the goals - and that's to standardize skilled nursing facility services throughout the state under managed care. And we want to advance a more consistent, seamless, and integrated system for managed care and really reduce that complexity and increase flexibility. And in managed care, we really believe and know that there's increased access to comprehensive care coordination, case management, and really a broad array of services that aren't available in Fee-for-Service in the same way. So, this enables us to meet those goals by carving in the skilled nursing facility benefit. Next slide, please.

Dana Durham:
The Skilled Nursing Carve-In APL Structure. So, the Skilled Nursing Facility APL topics are: benefits, our network readiness, leave of absences or bed holds, continuity of care, treatment authorizations, facility payments, Population Health Management, and finally, our policies and procedures. Next slide, please.

Continuity of Care for SNF Services. So, this is different than we've done continuity of care in the past and I just want to pause here to explain it a little bit. For most continuity of care, we've had beneficiaries raise their hand, but this continuity of care protection is automatic. That means that the beneficiary doesn't have to raise their hand or make the request. The managed care plan will reach out and provide that automatic continuity of care to the beneficiaries who are currently in skilled nursing facilities.

Dana Durham:
And the reason for that is we really want to prevent disruptions in care. So, we want to allow members to stay in their current facility as long as the following three conditions are met. The first is, they have to have an active license through CDPH. They have to have acceptable quality standards and that includes the standards of the managed care plan. And the managed care plan and the facility must agree to work together. And so, this continuity of care protection applies to all skilled nursing facilities transitioning on January 1st and it lasts for 12 months. So, after the 12 months, members may request an additional 12 months. As I said, this is automatic. People don't have to raise their hand. But if for some reason there is not access to the continuity of care, the managed care plan must provide the member with a written Notice of Action of an adverse benefit determination. And the member must be able to receive that adverse benefit notification and be given an alternate placement. Next slide, please.

Dana Durham:
Continuity of Care Providers and Other Services. Under continuity of care, members may continue to see their out-of-network Medi-Cal providers for up to 12 months. So the member, authorized representative, or provider contacts the new managed care plan to make the request. So, this is different than staying in the facility. To stay in the facility, the member doesn't have to make the request. But to continue seeing a provider who's not in that facility and not in the managed care plan network, the member must make a request. And the member can validate that they've been seen by the provider for at least one non-emergency room visit in the prior 12 months. Again, the provider must meet the standards of the plan and have no disqualifying quality of care issues, and the provider must be willing to work with the managed care plan. Members entering managed care residing in the SNF after June 30th, 2023 won't receive the automatic continuity of care into their skilled nursing facility, but they will be able to ask for this type of protection as well.

Dana Durham:
Other services really are the maintenance of current drug therapy, including non-formulary drugs until the member is evaluated or re-evaluated by the network provider. Managed care plans may choose to cover drugs that are not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered. Continuity of care provides continued access to transportation that includes NEMT, Non-Emergency Medical Transportation and NMT, Non-Medical Transportation, facility services, professional services, select ancillary services, and a level of care coordination. Next slide, please. Treatment Authorizations Requests. Managed care plans must name continuity of care for members in

a skilled nursing facility by recognizing any Treatment Authorization Request for that facility made by DHCS for the member enrolled in the managed care plan. Managed care plans are responsible for all other Treatment Authorization Requests for services in a skilled nursing facility, exclusive of the skilled nursing facility per diem itself, for a period of 90 days after enrollment or until the managed care plan is able to reassess the member and authorize and connect the member to medically necessary services.

Dana Durham:
Prior authorization requests for members who are residing or who are transitioning from an acute care hospital must be considered expedited, requiring a response time no greater than 72 hours - and that includes weekends. Next slide, please. As far as care management and care coordination, managed care plans are required to provide care coordination to support members. Care coordination is really scaled to the needs of a member. But for those in long-term care, it includes things like comprehensive assessment of the member's condition, determination of available benefits and resources, development and implementation of a care management plan with those performance goals, monitoring, and follow- up. Managed care plans must also assess individuals for additional needs that they may have, and those additional needs may include things like ECM or Enhanced Care Management, and Community Supports, Complex Care Management. The SNF Carve-In will not change the administration of Medi-Cal benefits that are carved out of managed care and will continue to be carved out of managed care. Next slide, please. Skilled Nursing Facility Long-Term Care Carve-In Promising Practices. So what are the best things people are doing? We're going to talk about those for a minute. Next slide.

Dana Durham:
If you look at this circle, it really shows some of what we've been able to identify as some really promising practices that happen in a long-term care facility. Those are really prioritizing that stakeholder engagement to support managed care plan and provider readiness. So talk early and often. The more you can have those conversations, the better it becomes. Identify challenges and best practices to better inform and prepare counties for the statewide CalAIM Long-Term Care Carve-In. And leveraging experiences from counties where long-term care is currently carved in. So if you look at the circle, all these are participants who really feed into those best practices. Next slide, please. Some promising practice topics are care management, outreach, and communications, long-term services and support liaison, and leave of absence bed holds. Next slide, please.

Dana Durham:
Care Management: Service Authorization Criteria. So, managed care plans new to covering long-term care, are not experienced with the long-term care authorization criteria. So, they're required to build existing requirements into their utilization management policies and procedures. And those policies and procedures are reviewed by DHCS. And they're also required to adopt a person-centered approach that should consider input and evidence of a medical need for a particular long-term care level of care for members, from the member, their responsible family members, and/or authorized representatives. The plan of care should include evidence of coverage needs from treating physicians, home caregivers, and/or family members. When you look at care management and looking at service authorization criteria, some promising practices really are to include the managed care plan contract references to the guiding statutes and regulations. So, the contract really should include that.

Dana Durham:
Within 30 days of a member's transition to a new care or back home, that managed care plan promising practice is to conduct a minimum of three attempts to confirm the member's needs are being met in the new setting. And also, the managed care plan should share with the facilities, the skilled nursing facility member placement acceptance criteria. And so, that helps people know what it takes to get into different SNFs and really ensure that there's an equitable placement of members at the appropriate level of care. And next slide. I think my colleague is going to be taking over this one, and I might have gone one past where you're taking over, Tracy.

Tracy Meeker:
No problem. Thanks, Dana. I figured I would just let you. You were on a roll. So we'll continue here on care management and talking about the authorization timeline. So, to transition to an appropriate level of care without delay is important for optimal patient outcomes in avoiding unnecessary hospital costs. Promising practices have identified areas that managed care plans and facilities may want to use contracts or policies and procedures to ensure clarity and smooth authorization processes, including easily understandable and readily available descriptions of the authorization request process and timeframe for long-term care services. Secondly, is ensuring staff at facilities have a clear understanding of timing and processes to request a reauthorization for residents whose existing authorization is nearing the end date. And finally, developing clear, specific, and available managed care plan escalation contacts for facilities and/or members to escalate concerns when there are delays and pending authorizations. And I think the panel might be talking about this a little bit more.

Tracy Meeker:
Also, creating and sharing retroactive authorization policies that allow providers more time to submit authorization requests. And it will be key for skilled nursing facilities and managed care plans to work together to ensure a common understanding of the authorization process in order to support their mutual members. Next slide, please. Okay. Transitioning just a little bit to outreach and communications. Managed care plans and facilities must meet ahead of the transition to conduct joint planning for the transition. This could include identifying any potential continuity of care issues for medical supplies, transportation, or other Medi-Cal benefits not included in the per-diem rate. Facilities and managed care plans should work together proactively to identify where facilities may be using providers or vendors not covered by the managed care plan so that all members have day-one coverage of essential supplies and benefits.

Tracy Meeker:
As far as community transitions, managed care plans should discuss any policies and procedures with skilled nursing facilities around how the managed care plan will be using Enhanced Care Management, Community Supports, or other care management services to identify members who may be able to transition back to the community and home, and how the facility can be engaged in that process. Next slide, please. Okay. For managed care plans new to the Skilled Nursing Facility LTC benefit, it will be important to build internal capacity and familiarity with the skilled nursing facility population throughout the plan. This will include ensuring call center staff understand the benefit and key staff understand the ways long-term care claims and payments may differ from other providers, and making sure care management staff are familiar with this population and are aware of the range of long-term care in-home and community-based services available to members. It's also important

to invest in communication channels between managed care plans and facilities. During the CCI transition, some Cal MediConnect plans conducted goodwill tours and visited all their facilities to begin developing relationships and lines of communication, which was highlighted by the Long-Term Care Work Group as a really good promising practice. Next slide, please.

Tracy Meeker:
Okay. The LTSS liaison is one of the key things that the work group identified. Facilities have reported challenges finding plan staff who understand or who specifically train in long-term care issues, obtaining authorizations for post-hospital care, and timely communication and problem resolution. To meet this need, a promising practice is for the managed care plans to have an LTSS liaison. This could be a plan staff or delegated entity staff to serve as liaisons for the long-term services and supports provider community to help facilitate member care transitions. These staff should be trained by the plan to identify and understand the full spectrum of Medi-Cal LTSS, including home and community-based services and long-term institutional care, including payment and coverage rules. This liaison could serve in both a provider representative and care coordination representative role just depending on how it fits best within the plan.

Tracy Meeker:
The promising practice is that the role is fulfilled by a managed care plan representative that works closely with skilled nursing facilities on a variety of different topics or issues. This role could also be called or referred to in different ways such as provider relationship specialist, long-term care specialist, LTSS or long-term care, or case managers. The intent is to highlight the importance of having a dedicated individual, or individuals, that may serve as a liaison between the managed care plans and skilled nursing facilities. And here, on the next slide, I think I'm going to transition back to Dana. I think we're going to move on to, yeah, the panel discussion.

Dana Durham:
Yeah. We're really excited to have with us today, Ed Mariscal. He's the Director of Public Programs and LTSS for Health Net, and Mark Hansen who is an Administrator at Rialto Post Acute in San Bernardino County. And I want to make sure you're both on as we head to the next slide.

Ed Mariscal:
I'm on, Dana.

Dana Durham:
Great. Thanks, Ed. And so, we'll start with you, Ed, because you came up first.

Ed Mariscal:
Sure.

Dana Durham:
I just want to ask you some questions about, how are staff identified for the LTSS liaison role. What do departments do where they reside, like Utilization Management, Care Management, Provider Relations? Just what can you tell us about who might be the prime person for this?

Ed Mariscal:
Thanks for the question. And again, thanks for the invite to participate today. Let me try to

answer this question in two parts. Because there's an easy response and then there's a more in-depth response to this particular question on the role of the LTSS liaison and how they were identified. The LTSS liaison role easily enough is part of the LTSS team within Health Net. That's the easy part. And we're a team under a broader Population Health team, and we live under the Utilization Management team. So that's a little bit about our structure. And the LTSS liaison essentially that we've chosen is me and my team, and we have the experience and we all have nursing home backgrounds. I also know and understand that I won't have all the answers all of the time, so I have a very large team around me that includes registered nurses, LVNs, and master's level social workers.

Ed Mariscal:
Those are the folks that are going to have those fancy titles like Care Manager, Long-Term Care Specialist, and Provider Relations Specialist that you mentioned earlier. Additionally, we work side by side with the contracting teams, the authorization teams, and the claims team. And I think of the 300- plus, or so, attendees in this session today, they've all met or many of them have met and talked to us before. You've talked to me. You've talked to my colleague Christina Adam or David Tran or Eleonore Clawson or Mary Hadley. These are all the folks that are part of the team that is going to make up this LTSS liaison role. Most of us are, again, under this Population Health umbrella. More importantly, we all work very closely together to ensure that our members and providers have everything they need as quickly as they need it. Supporting the providers and supporting our members is, of course, going to be the top priority and has been the top priority leading up to this carve-in. The vision here, of course, is to transform the health of our communities one person at a time. And we can only do that if our providers who are doing the work, the hard work of caring for our members, have all of their needs met and met quickly. Let me pause there, Dana.

Dana Durham:
Yeah. Thanks, Ed. And it sounds like you kind of have a hand on this. But what's the most challenging thing about operationalizing this LTSS liaison role, and how did you overcome that?

Ed Mariscal:
All right. So excellent question. You heard me say earlier about our vision, "Transforming the health of our community one person at a time." Keeping that in mind, we understand that individual facilities are going to have individual needs and if you've been to one facility, you've been to one facility. Thus, the challenge here is ensuring that we know and understand the specific needs of each facility in order to ensure that the right LTSS liaison is assigned. The counties of Amador, Calaveras, Glenn, Yuba, that only have one nursing facility within the county, their needs are going to be very different from Fresno county that has 31 facilities or very different from Sacramento that has 35 facilities, and certainly very different from Los Angeles county that has 378 facilities and almost 40,000 beds within the county. So once we know and understand deeper the individual needs of the facility or what the ongoing individual needs of the facilities are, we will make sure that the right LTSS liaison is their point of contact.

Dana Durham:
That's great. And it sounds like you've done this next question pretty well. So just want to hear about how you prepared your LTSS liaison for their role. What does their training look like?

Ed Mariscal:
Sure, thank you for that. And I always appreciate the opportunity to talk about the team and how wonderful they are. So our team of liaisons, but really the broader team, the team that I talked about earlier, the Davids, the Eleanores, the Christinas, the Marys, and my team, we really began this process and we began this work back in, what was it, 2018 or 2019? When that first notice came out that long- term care was going to be carved in before we were involved in a public health emergency. When that information was first introduced is when we gathered the team and started building it. The training included everything from reviewing the contracts and the claims processes, the authorizations, and the care transitions that have all been part of the work that we've been doing in our CCI counties with the idea that this is something that we're going to scale up to all of our counties. Additionally, and more importantly, we understood who the subject matter experts are for all of these warm handoffs that are going to be necessary to support our facilities. Our core team meets regularly with CAHF and let me put in a plug for the CAHF conference that's going to take place in about a week and a half. I encourage you to reach out to me or anyone on my team, we will be there and we can talk to you in a little bit more detail. But this training, this education, this supporting that we've been doing has really dated back to 2018/2019 when this first started being talked about so that we are all aligned and we know as many of you as possible on this call.

Dana Durham:
Thank you so much, Ed. And don't go too far because I'm going to ask Mark to talk, and then have both of you answer some questions. Mark, are you here? I haven't seen-

Mark Hansen:
I'm here.

Dana Durham:
Great. Thank you so much for being here. As I said-

Mark Hansen:
Oh, thank you.

Dana Durham:
Mark's one of our providers. I've got a couple of questions for you, Mark. So the first one is, what's been helpful or critical about the LTSS liaison staff and how has it worked well? And what are the top three ways your contact at the MCP has helped support your residents?

Mark Hansen:
Well, first of all, thanks for having me. But the real goal of post-acute care and I consider after the hospital still kind of post-acute care is to keep the patient from going back to the hospital. The patient doesn't want to go, the plan doesn't want to pay for it, and the skilled nursing doesn't want the readmission. So, if we're all working on that same goal, a lot of the rest of these three items are going to make a lot of sense. So, allowing or authorizing a patient to skill in place to prevent that rehospitalization is really important. So, if they're developing a UTI and we need to do a few days of antibiotics, getting that authorization for a skilled service just for a few days is really important. Maybe they had a fall, maybe something else happened that maybe they're dehydrated. These are reasons that we would want to skill the patient in place and not have to send them back to the hospital.

Mark Hansen:
Getting authorization for transportation – if we can't get them to dialysis, they're going to get very sick very soon. So that's a big issue. Currently, we have problems with enough providers. So, I would say from Ed's side of the fence, having enough transportation companies to call on is really important because at times there's just not enough drivers to handle the load. And then thirdly, getting specialized equipment authorized, whether it's low air loss mattresses to help prevent pressure sores, whether it's bariatric equipment to assist those patients, whether it's beds or... But those aren't standard pieces of equipment that we have.

Dana Durham: Great and thanks. And the other question I have for you is what trainings or learning collaborative convenings that you've worked with the managed care plan have been most helpful for you guys?

Mark Hansen:
Well, I think when you're dealing with any new insurance plan, whether it's part of this carve-in or not, you need to figure out what they cover, and what's part of the daily rate, what's part of the custodial rate, what's part of the skilled rate, and what's paid for but requires a separate authorization. For example, there's medications that are expensive that will be covered but you have to get a special authorization. There are pieces of equipment that will be covered with a special authorization. So, I think really digging through the contracts and understanding them helps you help the LTSS so you guys can work together and say, "Hey, this patient has this going on. What's covered? What needs a special auth?" So, that relationship is huge. And then the other part is, what is the process of getting the authorization, and how quickly is that turned around? We have generally a separate long-term care case manager or LTSS, and then a separate short-term. So, if we're skilling someone in place, there needs to be a seamless handoff between the long-term care, then hands over to the skilled care case manager and then back to the long-term, even if it's just for a few days.

Dana Durham:
Thank you so much. I'm going to the next slide, but it just really is a slide that we're going to really give people an opportunity to ask questions specifically about this LTSS liaison and their role. I know there are a lot of questions in the chat, but just wondering, Kristin, if there are any about the LTSS liaison, or if not, if we can see if anyone has one.

Kristin Mendoza-Nguyen:
Yeah, there's a good question from Jack Dailey, "Does the LTSS Liaison Unit track and monitor the grievances and appeals being received by their MCP so they can intervene and engage when a member in LTC or SNF or other representative is filing a grievance or appeal. How about when LTC or SNF residents interact with other divisions?"

Ed Mariscal:
Let me start with that one. I may ask you, Kristin, to repeat at least part of it. But I've worked with Jack, and so if the member calls the LTSS liaison, if the member calls me, or if the member calls me through Jack or someone from Jack's team and it is an identified grievance, we will connect them with our grievance team. So, it's a formal grievance and we respond to the grievance using all of the regulatory deadlines, timelines, et cetera. So that we identify it, track it, trend it, but also learn from it and use it as a teaching opportunity for the broader team. And when I talk about the broader team, it is not just the LTSS team that

receives the training or the education on whatever any of the grievances are. It's the broader, more expanded team that I talked about that is going to have some of that information shared with them through a training or education. The contracting team, the non-clinical team that works on your authorizations. Regardless of what the grievance is, all of the team is brought in so we can all learn from it so that we don't do it again.

Mark Hansen:
And then we receive the grievance after the plan receives it from the patient, and then we're required to respond and vet out what the issue was. And we do a lot of the same sorts of things where if it's really legitimate and we have a systems issue, then that's what we have to work on.

Kristin Mendoza-Nguyen:
Great, thank you. And then this question's for Dana, “Is there an official list of LTSS liaisons for each MCP? Will it be published on the Medi-Cal website?”

Dana Durham:
At this point, this requirement has not come into being yet, and I hear the ask for a list, so it will either be on the managed care plan’s web... I know it will be on the managed care plan’s website, how to get in contact with the liaison, but I don't know if we're going to have it on the website yet. It's a good ask. I think it's great. I'll just need to take it back and see where we'll be with it.

Kristin Mendoza-Nguyen:
Yeah. Okay. Any questions... Oh, go ahead, Dana.

Dana Durham:
I did see another one for Ed, actually, “Do you know about HICAP [Health Insurance Counseling and Advocacy Program] and refer residents or their families to HICAP?”

Ed Mariscal:
Yes. And if the need arises we will make all the connections. So that's part of the role of the LTSS team and that's part of the role of the liaison in general. Not only to support the nursing facilities but really especially when we start looking at the opportunity to transition our members out of long-term care. If they meet the criteria and if there's that opportunity, we will connect them to any community-based, any additional service, health plan benefit or not that will help them be successful in the community, either through services, through training, through education, whatever the case might be. And we work with as many community-based organizations as possible to make sure that that transition is successful.

Ed Mariscal:
Mark mentioned earlier that he doesn't want readmissions. We don't want readmissions, and we don't want to move people just for the sake of moving people. That's not safe and that doesn't meet the goals or the visions that we've all laid out for each other. We want to make sure that it's thorough, complete, successful, and that means leaning on all of our community-based partners, whether they're managed care providers or not.

Dana Durham:
Great, thank you. Any more questions that you saw, Kristin?

Kristin Mendoza-Nguyen:
There's a number of questions that came in earlier, but we do... I think we'll cover those either in the FAQ or in the next opportunity. I just want to make sure we have time to also transition-.

Dana Durham:
Are you trying to keep me on track? Kristin Mendoza-Nguyen:

Yes. So, we can transition I think to the Leave of Absences and Bed Holds.

Dana Durham:
Yeah. And Mark, we'll have a conversation in a minute but we're going to turn it over right now to Tracy to talk about Leave of Absence and Bed Holds.

Tracy Meeker:
Thanks, Dana and Kristin. So, before we go on the next several slides talking about the details, one of the things I would like to note is that leave of absence and bed hold requirements have been in statute for quite some time, so these aren't anything new. But we do understand and we've heard from a lot of providers, health plans, that the education and the awareness of what the requirements are, need to be elevated, so that's why we want to focus on these. So, they technically are not new, but we really want to make sure through this carve-in, that both the managed care plans and the facilities are aware of what the requirements have been and still remain to be. So, I just wanted to note that before we get into the details. So next slide, please.

Tracy Meeker:
A key member protection for members residing within a skilled nursing facility includes a leave of absence and bed holds. Leave of absence and bed holds are periods of time when a facility resident may leave the facility while retaining the ability to return, and the facility will continue to receive some payment. Plans may require prior authorization for bed holds and leaves of absence. And we've heard some plans do and some plans don't, so that's where communication is important. Leave of absence and bed holds are key to maintaining the level of care needed for members, should their care setting need to change temporarily. Compliance to the Leave of Absence and Bed Hold policies help ensure members maintain their bed during a leave of absence and allowing for continuity of care for members. Next slide, please.

Tracy Meeker:
Okay. A little bit more about the requirements here. Managed care plans are required to ensure bed holds are utilized appropriately. Members must be allowed to return to the skilled nursing facility they previously stayed in or resided in. And the managed care plan is responsible for the coordination of that transition, like most likely to a hospital and back or to some other service and back. Managed care plans should address any skilled nursing facility denials of bed holds with the skilled nursing facilities to ensure appropriate member access. And finally, managed care plans must ensure that skilled nursing facilities notify members in writing of their right to a bed hold provision, in writing, upon their admission to the skilled nursing facility. And then secondly, upon transfer to a hospital or some other setting that's outside of the skilled nursing facility. Next slide, please.

Tracy Meeker:
Okay. This slide has quite a few details. So, let's just start at the top. An important item to understand regarding leaves of absence is that there are specific time limitations, or durations, that are listed here on the slide and there's three big categories. There are detailed rules regarding leave of absences and payment. For example, a leave of absence payment is not made if a member is discharged during the leave of absence or discharged within 24 hours after returning to the skilled nursing facility. Skilled nursing facilities can learn more about leave of absence and bed holds in the Medi-Cal requirements, which are listed here on the slide. And then guidance on payment and rules for bed holds and leave of absences are available on the Medi-Cal provider manual. Next slide, please.

Tracy Meeker:
Okay. And then, how can skilled nursing facilities and managed care plans prepare to support either a leave of absence or bed hold for their members? Bed holds are a covered benefit under a member's Medi-Cal benefit. Skilled nursing facilities should become familiar with the appropriate Utilization Management contacts at the managed care plan, like what we were just talking about with Ed and Mark, to ensure that the authorization may be attained if needed. Some managed care plans may require an authorization while others may not. Skilled nursing facilities should work closely with the UM and/or LTSS liaison at the managed care plan to ensure that appropriate documentation is provided to obtain approvals and authorizations as needed. Managed care plans may require prior authorization for leave of absence and bed holds. So, there's not a Department requirement, it's really up to the plan to determine what their policy is.

Tracy Meeker:
Timely and accurate authorization submissions coupled with an understanding of the managed care plan timeframe for review of authorizations is critical to ensuring member access to care. And I think this is something Mark just mentioned also. For residents in a nursing facility, either a NF-A or NF-B level of care, that are admitted to an acute care hospital, managed care plans will cover a bed hold for a period of seven days when a member is admitted to acute care. Claims for bed holds will be denied if a member's stay in a hospital will be longer than seven days. It will be critical for skilled nursing facilities and managed care plans to work closely together to obtain a bed hold authorization in order to support the member. And again, that's if the authorization is required by the plan. And finally, providers can learn more about Bed Holds in the Medi-Cal requirements in the provider manual and in Title 22 CCR Section 72520. And that might be cut from this slide, but anyway, next slide, please. Okay. I think I'm going to transition over to Dana now to talk about some promising practices here.

Dana Durham:
Yeah. I mean, I think as we do that, let's talk real quick about that people should communicate, managed care plan and facility, really have those ongoing communications about how to be timely and accurate, how to talk about a change in a member's status and work together before so that needs are met. And finally, ensure the internal plan staff know what they're doing. So, we're going to turn to the next slide, please, and invite our panel back. And I see Ed's here, which is great. Ed and Mark. And then we'll just go to the next slide, please. Let's see. What has been the most challenging part of ensuring that members may appropriately exercise their leave of absence and bed hold rights and protections, and how have you overcome that? This is a little confusing to me, so it'd be helpful if you could help me understand it, Ed.

Mark Hansen:
Yeah, I can take that one.

Dana Durham:
Or Mark. Yeah, great. Thank you. Mark Hansen:
Because it was a little confusing the way it was written a little bit to me also. So, first of all, let's go to the leave of absence. That's generally your long-term patient, not your skilled patient and you get the 18 days per year and you need to have a physician's order. We need to have medications prepared for them to take for any amount of... up the time they're going to be gone. Someone has to be available to help them administer the meds timely. If they can't do their own injections then someone else would have to be trained to do that. So, there's a little more than just saying, "Yeah, they can just take off for a few days." It has to be part of the plan. Everyone knows where they're at. Everyone's been trained to administer their care.

Mark Hansen:
The LOA part's a little bit easier. The bed hold, it almost looks like the way was written, if they're there more than seven days, you don't get paid for the seven days. You do get paid for the seven days because when you send them out if the anticipation is that they will be back in your building in less than seven days, you can do a bed hold. Now you have to have a bed for them. You don't have to have the same bed for them. So if you had had some other admissions and you have to move patients around a little bit to compensate for maybe different genders to be together. You just have to have a bed for them. And again, one of the main reasons we'll get denials on a bed hold is because they don't have the physician's order. So as soon as the bed patient goes out, the nurse writes the order, gives it to the case manager, a case manager sends it off to the plan and that's day one, and that's the way it goes.

Dana Durham:
Thanks so much. So, just wondering, what are some of the promising practices that you want to make sure people know about around leave of absences and bed holds?

Mark Hansen:
Yeah, well the leave of absence is really more of an internal readiness for the patient to go home, or maybe they're trying out going home for a week to see if that's something they can sustain with their support group. So, that's really a lot of communication within the building to see if they're ready. And then certainly, we keep the plan in the communication loop but they're not so much dealing with how this is going to happen. And then the bed holds, really the best practice is, when the nurse writes the discharge to the hospital, she writes a bed hold order, and the following morning, the medical records goes through the discharge documentation and verifies that bed hold order is there. At times there'll be a Bed Hold Order, but the patient doesn't actually have Medi-Cal, not part of this plan. In that case, there is no bed hold reimbursement.

Dana Durham:
Great. Thank you so much. Mark. Ed, anything you want to add on to this or...

Ed Mariscal:
Sure.

Dana Durham:
I just want... Yeah, great. Ed Mariscal:
Let me just add from the health plan perspective, because as Mark was talking, I was having flashbacks to my days as an administrator, coincidentally, also in San Bernardino County where he is today.

Dana Durham:
You must know each other.

Ed Mariscal:
We do. So I know and I understand that we at the health plan can be an administrative burden to the nursing facilities. I get it. The goal here is to not be. We don't want to get in the way of people actually providing care for the people we're serving. If we are truly going to highlight and focus on our vulnerable populations, we have to get out of the way as much as we can and let them do their job. So our goal here is to make it as easy as possible for our members to exercise their LOA and bed hold rights. But part of that comes by stepping out of the way. Thus, the decision that we've made and the best practice that we've identified is to not require an authorization for a bed hold or a leave of absence.

Ed Mariscal:
If the nursing facility needs our input for the leave of absence that Mark was talking about, that let's go try being at home for a week. We can certainly participate in the care planning process. We can certainly participate any way they need us to participate to support our member. If our member wants us to participate, we will also do that. But for the bed hold, we don't require the authorization. We just ask the facilities to when they submit their claim, that their claim includes the appropriate revenue code for the appropriate days. Now there is this guidance as you were reading as part of the All Plan Letter 22-
018. That requires a health plan to ensure nursing facilities notify the member, or the authorized representative, in writing of their right to exercise the bed hold provision. Now, on the call today, I mentioned a few folks earlier. I also have Karen, who is my Project Manager that's by my side working through all of this, and some very esteemed colleagues, Talia and Chelsea that are also helping through all of these processes.

Ed Mariscal:
We know that all of the facilities already communicate in writing to our members, or to our members' families at the time of the trip to the emergency department. We also know that communication around the bed hold is part of the standard admission agreement. So they've had these conversations already with every single person in their building. How do we ensure that the member is notified? Something we're working through. Keeping in mind that we want to make sure our members are supported, but that we're not being an administrative burden to the facilities. Additionally, I don't want... We're in 29 counties and contracted with over 900 nursing facilities, I don't need 900 faxes every single day. I don't think that helps anybody. But we will be looking and auditing and ensuring that when necessary all of these conversations have taken place.

Ed Mariscal:
If we get concerns from the Ombudsman, from the hospital, that our members are not being accepted back, if we get calls from regulators, if we get calls from neighborhood legal or other entities that we have nursing facilities refusing to take our members back, then we will

get involved and we will start looking at it. And then we'll have the occasional audit to make sure that it all is happening the way it should. But again, we want to make sure that we're helping transform the health of our communities. We want to make sure that our nursing facility partners are supported, and we want to be mindful of the administrative burden that we can potentially cause with all this added work. So, all of that to say, we're going to continue this partnership and do the best we can.

Dana Durham:
Thanks so much. Let me just say, Ed, you've gotten some love in the chat. People think you're wonderful. So, I'll start with that. But-

Ed Mariscal:
I'll pay them off after the call.

Dana Durham:
Yeah, I didn't get the same type of love. I'm just saying you must pay them. Anyway, Kristin, I know we only have a couple of minutes, is there anything that you'd want to highlight? I wish we had more time for the panel discussion because it's been great. But, I think we're just going to have to go to the next slide. And I just want to thank you, Mark and Ed, for being here.

Kristin Mendoza-Nguyen:
Yeah, there's...

Dana Durham:
Go ahead.

Kristin Mendoza-Nguyen:
... there’s like one question I think that came in about bed holds.

Dana Durham:
Okay.

Kristin Mendoza-Nguyen:
“What if the patient is not admitted but is on acute hold over midnight?”

Ed Mariscal:
If they are not in the nursing facility bed at midnight, that's a bed hold.

Kristin Mendoza-Nguyen:
Okay. Great. And I know... I just want to acknowledge there were a lot of questions today throughout the presentation, and there is going to be an FAQ document that will be released. A good portion of them are covered in the FAQ and we will also be adding any FAQs questions to those that were not addressed. So I just want to acknowledge that because I know there's been lots of questions and requests in the chat. And with that, I'll turn it over, Dana, to you to help close this out for today.

Dana Durham:
Thank you for acknowledging that. And these are rich questions. Oh really, Mark and Ed, thank you so much. You've just been a wealth of knowledge. I do want to say there are great

questions in the chat. I wish I could get to all of them. I can't. Let me go ahead and tell you the next steps. We are having a Long-Term Billing and Payment Rules webinar. That'll be December 2nd. And then Best Practices for Care Transitions is going to be in January. And then Best Practices for Care Management will be in February. Look for those. We would love to have you join those. Next slide, please.

Dana Durham:
Resources and Contact Information. We do have an APL 22-018 for Skilled Nursing Facilities. We will be releasing soon. That Frequently Asked Questions document you asked about, it's important that we have that and also resources that are out there. CalAIM SNF Long-Term Care Carve-in resources for Managed Care Plans. Look for both of those. And then at the bottom, there's some other resources that are available. Next slide, please. We do have an appendix to this. They'll be available online. I do want to say that we are so glad you joined. We will look at your questions and get to them and look forward to continued conversations. And once again, thanks, Ed, Mark, Tracy, and Kristin for being on this webinar with us. Thanks. Have a good day.