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California Advancing and Innovating Medi-Cal (CalAIM)

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SPEAKERS

Kristin Mendoza-Nguyen
Bambi Cisneros
Dr. Laura Miller
Dr. Priya Motz
Tracy Meeker
Beau Bouchard

Kristin Mendoza-Nguyen:

All right. Good afternoon and happy Friday and welcome to today's webinar, the CalAIM Skilled Nursing Facility Carve-In: Policy Update. My name is Kristin Mendoza-Nguyen, Aurrera Health Group, supporting DHCS on the LTC Carve-In. We are delighted that all of you were able to join today for the final webinar in the DHCS SNF Carve-In webinar series. We have some great presenters for today's webinar. We have Bambi Cisneros, Assistant Deputy Director of the Healthcare Delivery Systems Division at DHCS, Dr. Laura Miller, Medical Consultant for Quality and Population Health Management Division. Dr. Priya, Quality and Health Equity Transformation Branch Chief, Quality and Population Health Management Division, Tracy Meeker, Managed Care Quality and Monitoring Division, and Beau Bouchard, Assistant Division Chief at the Capitated Rates Development Division at DHCS. The slides and the meeting materials will be available on the webpage, and you can find those materials in the chat.

Kristin Mendoza-Nguyen:

All materials from previous webinars are already on the webpage. Next slide. Just some quick reminders. We do ask to add your organization to your Zoom name. It helps us track any questions that need follow up. So if you just click on the participant's icon at the bottom of the window and hover over your name, you can select “rename” and add your organization as you would like it to appear.

Kristin Mendoza-Nguyen:

Couple of meeting management items on the next slide is this webinar is being recorded. Participants are in listen-only mode, but we do encourage you to use the chat feature to submit any questions that you will have. And with that I will turn it over to Bambi to kick us off for today's webinar.

Bambi Cisneros:

Great, thank you very much Kristin. And welcome, everyone. Thank you for joining us this afternoon, and happy Friday. So I think what we'll do is first go through the agenda here. So, outlined here is what we will cover in today's webinar. So, we will provide a brief overview of the Skilled Nursing Facility Carve-In and share some post-transition reminders. And then we will dive into the APL updates. We have made several updates to the initial APL since it was first published in September. We are working on releasing that updated APL in a week or so. But we will preview that today, this afternoon.

Bambi Cisneros:

And this updated APL will supersede the current APL, which is APL 22-018. And then we will also go over the PASRR, or the Pre-Admission Screening and Resident Review in facility payment sections. We will then have an opportunity for some Q and A, and then after that we will continue with the additions of the APL, which also include Transitional Care Services, Quality Monitoring, Monitoring and Recording in the Long-Term Services and Supports Liaison sections, and then offering another opportunity for

Q and A. And then finally we will close out with next steps. And that's what we will cover this afternoon. You can go to the next slide please.

Bambi Cisneros:

So, I will go over some reminders on some key APL policy requirements and so we will cover some key points on Authorizations, Continuity of Care, Network Adequacy and Clean Claims in the next few slides. So, just a brief overview and reminder that on January 1st, 2023 we did carve-in long-term care skilled nursing facilities statewide, which means that Medi-Cal Managed Care Plans in all counties are now responsible for covering the long-term care benefit for SNFs, or skilled nursing facilities. And that enrollments in Medi-Cal managed care is mandatory for all Medi-Cal beneficiaries that are residing in a skilled nursing facility.

Bambi Cisneros:

And the reason why we did that is that the Skilled Nursing Facility Carve-In is part of CalAIM's Benefit Standardization Initiative. One of the key goals is really to just standardize services under managed care statewide so that it reduces complexity and we have an ability to really oversee this benefit as a whole, and as well as ensuring that there's access and care coordination that happens in managed care today. Okay, next slide please.

Bambi Cisneros:

And here on the slide we do have a map of the state of the various plan models, which prior to the Carve-In we did have plan models differ by county and the coverage of long-term care skilled nursing facilities also varied by plan model by county. And so we just provided some links and references here of those managed care plan models if you are interested in reviewing further information. And so just one brief overview of Medi-Cal managed care is that the Department does contract with Medi-Cal Managed Care Plans to then provide the provision of, and delivery of healthcare services. And so managed care plans do that by a network of providers that they then pay their providers directly.

Bambi Cisneros:

And, again, I think just talking about all of the different standardization that occurs in managed care as we go through the next few slides is that the overall goal of Medi-Cal Managed Care is really to provide that coordinated care and high quality as we do have monitoring processes in place for managed care and it is cost-effective as well. We can go on to the next slide please.

Bambi Cisneros:

Okay. So we will touch on these four APL provisions in the next slide. I think we can go to next slide. So for authorizations it is really important for this transition that members have continuity so that they do not experience gaps in care. And so with that, we implemented provisions pertaining to authorization.

Bambi Cisneros:

And when it comes to Treatment Authorization Requests, or TARs, continuity of care applies. And this means that for members that transition from fee-for-service to managed care, that managed care plans are responsible for honoring those existing and valid TARs that were approved through fee-for-service for a period of 12 months or for the duration of the Treatment Authorization Request, whichever is shorter. And managed care plans are also responsible for all other approved TARs for services outside of what is included in the per-diem rate for a period of 90 days after the member is enrolled in a managed care plan, or until the managed care plan is able to reassess for medical necessity.

Bambi Cisneros:

And we do have all managed care plans that are required to act upon prior authorization request timely. And so here, for members who are being discharged from a hospital to a skilled nursing facility, we do consider these to be an expedited request. So managed care plans must respond to these service authorization requests within 72 hours upon notification of the request, which does include weekends. And we can go on to the next slide which has a little bit more there.

Bambi Cisneros:

So, a little bit more on expedited authorizations. And so, as mentioned in the previous slide, the 72-hour time period for expedited authorizations does include time outside of normal work hours, which includes weekends and after hours. And so if an expedited authorization does not receive a response within this required time period, the next step in the process as a provider is to file a complaint through the managed care plans grievance process. And we did include information on how to file this information in the appendix of this slide deck. And it's also outlined in All Plan Letter 21-011, which we have linked here.

Bambi Cisneros:

Next slide please. So, in terms of continuity of care, there are three aspects of continuity of care for Medi-Cal beneficiaries residing in a skilled nursing facility. And the first element of continuity of care pertains to the skilled nursing facility itself. And this really applies to members who were already in a skilled nursing facility on January 1st and were previously in fee-for-service Medi-Cal, but continuity care could also apply to both providers and services which we'll go over in later slides.

Bambi Cisneros:

And one of the guiding principles for this transition is to prevent and minimize disruptions in care. So when it comes to the facility, unless the managed care plan determines that relocation is medically necessary, we really wanted members to be able to stay in the facilities where they were residing. And so transitioning members can stay in their current skilled nursing facility as long as certain conditions are met.

Bambi Cisneros:

And so, we've outlined those here on the slide, which is that the facility is licensed by the Department of Public Health, that the facility needs acceptable quality standards including the plan's professional standards, and also that the facility and the managed care plan agree to work together. And although continuity of care is for 12 months, it can be extended upon a member request to the plan. And again, wanted to really highlight here that this continuity of care protection is automatic, which means that the member does not have to request continuity of care in order to stay in the facility.

Bambi Cisneros:

Okay, go to the next step please. And then the second aspect of continuity of care applies to providers. To stay with their existing provider, members must contact their managed care plan to request to keep seeing their provider. And in addition to the member, the member's authorized representative or provider can also make that continuity of care request on the member's behalf. And so similar with the continuity of care provision for skilled nursing facilities, there are certain conditions that must be met in order for continuity of care to be granted.

Bambi Cisneros:

And in this particular case, those conditions are that the member, authorized representative, or provider makes the request, that there is a preexisting relationship between the member and their provider, which we are defining for the member to have seen that provider at least once during the previous 12 months for a non-emergency visit. There are no quality of care issues that the plan has with the provider, and then of course the provider and the managed care plan are willing to work together.

Bambi Cisneros:

And so, here on the slide what we are really highlighting is that continuity of care applies to certain providers. And those providers include primary care specialists and some ancillary providers, but they don't apply to all ancillary providers, which we will cover in the next slide. And then one thing to flag also on this slide is that after June 30th, for members newly enrolled in managed care, they will need to request CoC or continuity of care as per our current continuity of care process today. And we can go on to the next slide.

Bambi Cisneros:

So finally, the third aspect of continuity of care applies to other Medi-Cal services. And so what that means in this context is that for members they will have continued access to these services, but not necessarily the same provider who was providing those services. And so that means that members may need to switch to the plan's in-network provider in order to continue receiving these services. So for durable medical equipment, or for DME, managed care plans must allow the transitioning members to keep their existing DME in medical supply from their existing provider for a period of 90 days or until the managed care plan is able to reassess and the member has the new equipment or supplies in hand.

Bambi Cisneros:

And then after the 90 days, managed care plans may reassess the member's authorization and require the member to switch to an in-network DME provider. And also, if plans and providers are unable to work together, similar to how we highlighted on the slides, there's certain agreements or conditions that must be made, which include agreeing on rates and meeting professional standards. The managed care plan will find members another provider to provide those services within its own network.

Bambi Cisneros:

Okay, next slide please. So, switching over to Network Adequacy. So, as part of plan readiness, as plans were ramping up and building their networks, the Department did establish network readiness requirements and we highlighted that in APL 22-018. And what those readiness requirements were specifically is that managed care plans were required to attempt to contract with all skilled nursing facilities in their service area, as well as contract with a minimum of 60% of skilled nursing facilities.

Bambi Cisneros:

And so those were the readiness requirements leading up to the transition. And so now that we are post-implementation, it is the Department's intent that managed care plans transition from those minimum contracting requirements to ongoing network capacity building, because we really want to ensure that access to skilled nursing facilities to members really do occur. And so we do encourage plans to contract broadly with all enrolled and licensed skilled nursing facilities as they are enrolled and licensed through the Department of Public Health.

Bambi Cisneros:

And the Department did send guidance to all managed care plans that reminds them of this requirement. Do know that some Letters of Agreement were made in order to make sure that continuity applies and that members don't experience gaps in care. But we do remind plans that LOAs, or Letters of Agreement, do not count towards that contract requirements, because we don't see that they're really intended to be used for long-term arrangements. And Letters of Agreements should really only be used during the time period while contracts are in progress. And so that is part of the guidance that we gave to the managed care plans in terms of ongoing network adequacy.

Bambi Cisneros:

And then move on to the next slide please. Thank you. And so in terms of clean claims, clean claims is a contractual requirement today and that requirement is 90% to be paid within 30 calendar days and 99% of clean claims to be paid within 90 calendar days. And in order for a skilled nursing facilities to be paid in a timely manner, they also need to submit clean claims so that managed care plans can more easily process those claims.

Bambi Cisneros:

We're a little bit into the transition now and we have been hearing from some managed care plans that they have reported issues with some facilities submitting clean claims and we've also heard from some facilities that working with managed care plans that have varying processes has also been challenging. And so I think to that end we would say that we would encourage managed care plans to offer outreach, education, and support for skilled nursing facilities to help them submit clean claims in order to meet those clean claim requirements.

Bambi Cisneros:

And many plans have trainings and checklists that facilities can use. So we really do encourage managed care plans to share those out, as we do expect that managed care plans and the facilities work collaboratively together to ensure that there's a common understanding of billing and claims processes. We do also expect that managed care plans train their providers on those billing protocols as well so that everyone is on the same page.

Bambi Cisneros:

And then there is a requirement for managed care plans to have an LTSS liaison, which is a single point of contact and we do see that liaison to fulfill the role of supporting and helping resolve any claims challenges. Okay, we can go to the next slide please. Here on this slide we are sharing additional resources that can provide further tips and resources to support billing. And linked on this slide are things on topics pertaining to claim forms, code conversions, and balance billing. So we wanted to provide that here so you have that information. And so we can go to the next slide please. Okay, so we will then go into the PASRR. So Tracy, I'll pass it over to you.

Tracy Meeker:

Thanks, Bambi. So I'm going to spend a little bit of time highlighting which are, it's a new portion of the APL, so not just an update, but a whole new section starting with the Pre-Admission Screening and Resident Review, which we all call PASRR. So if we can go to the next slide?

Tracy Meeker:

The Department included a section on PASRR to prevent inappropriate nursing facility admission and retention of individuals in accordance with federal law. So, the PASRR requirements are applicable for all Medicaid certified nursing facilities and for all admissions, regardless of payer source. Managed care plans are required to work with DHCS and network providers including discharging facilities, or admitting nursing facilities, to obtain documentation validating this process being complete.

Tracy Meeker:

The PASRR process is required to ensure that individuals who may be admitted into a nursing facility for a long-term stay be preliminarily assessed for serious mental illness, and/or intellectual or developmental disability, or related conditions. Managed care plans are also required to work with DHCS and network providers including discharging

facilities or admitting nursing facilities to obtain this documentation regarding that the PASAR process is complete. And we will be issuing further implementation guidance in the near future. So more to come on that. We can go to the next slide.

Tracy Meeker:

So PASRR can advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered, along with personal goals and preferences in planning long-term care. DHCS's PASSR section is responsible for determining if individuals with serious mental illness, or SMI, and/or intellectual or developmental disability, IDD or DD, or related conditions, require nursing facility services considering a least restrictive setting and specialized services.

Tracy Meeker:

This is achieved by completing the PASRR process which consists of three different levels, and I'll go through them quickly here. The level one screening is submitted online by the facility and is a tool that helps identify possible SMI, or IDD, DD, or RC. If the screening is positive for one of these conditions, then a level two evaluation will be performed. And the level two evaluation helps determine placement and specialized services.

Tracy Meeker:

DHCS is responsible for SMI level two evaluations, which by law must be performed by a third-party contractor and DDS is responsible for the IDD, DD, and RC evaluations. The SMI determination will be available online and will include placement and treatment recommendations for the individual, and the determinations will be issued by DDS. All PASRR questions and requests need to be directed to the DHCS IT service desk, and the service desk requires a first name, last name, and phone number before a work order ticket can be created. So I think from here we are going to transition over to Beau to talk about some payment stuff.

Beau Bouchard:

Thanks Tracy.

Tracy Meeker:

Sure.

Beau Bouchard:

Yes, I will take over the payment stuff. Yes, I'm going to be going over some portions of the APL that we've amended to provide clarity to managed care plans and providers through our conversations. So, next slide.

Beau Bouchard:

So, as a reminder, the managed care plans in counties where extended coverage of SNF services is newly transitioning from fee-for-service delivery system to the managed

care delivery system must reimburse network providers of SNF services for those services at exactly the Medi-Cal Fee-for-Service per-diem rates, applicable to the particular type of institutional long-term care provider. And then for managed care plans and counties where extended SNF services were already Medi-Cal Managed Care covered services, they must reimburse the network providers of SNF services for those services at no less than the Medi-Cal Fee-for-Service per-diem rates applicable to the particular type of institutional long-term care provider.

Beau Bouchard:

And within the APL we've now added some specificity around the SNF services that are included in the requirement. So you can see to the right of the slide here where we've just expanded a little bit on the SNF services, which include the room and board, nursing and related care services, commonly used items and equipment, supplies, and services, Leave of Absence days, and bed holds. Next slide.

Beau Bouchard:

Some other areas that we've added clarity on. So we've added language that makes clear that the Medi-Cal Fee-for-Service per-diem rates for SNF services are all-inclusive rates that accounts for both skilled and custodial levels of care, and they're not tiered according to the level of care. So they are like a blended per-diem rate that accounts for both levels. And that ancillary services are excluded from the services bundled under the Medi-Cal Fee-for-Service per-diem rates. And then we've clarified language that the reimbursement required did not apply to any other services provided to a member receiving SNF services such as, but not limited to, the services under 22 CCR §51123(b), (c), and §51511(c) and (d).

Beau Bouchard:

Also, SNF services provided by an out of network provider or services that are not provided by a network provider of SNF services. Such non-qualifying services are not subject to the terms of the CMS-approved state directed payment and are payable by the managed care plans in accordance with the MCP and the provider contracts. And the reimbursement requirement does not govern payments not directly for SNF services rendered, such as, but not limited to, provider incentives and pay-for-performance payment arrangements.

Beau Bouchard:

Next slide. To provide more clarity and expand on the therapy services that are included in the per-diem rate, it's important to understand that routine therapy services are services that are covered under that per-diem rate, and it's the therapy services that are needed to maintain a patient's current functionality. So therapy services provided to the patient that are covered by the per-diem rate include, but are not limited to, keeping residents active and out of bed for reasonable periods of time except when contradicted by a physician's order, supportive and restorative nursing and personal care needed to maintain maximum functioning for the recipient, care to prevent formation and progression including the changing positions of bedfast and chairfast recipients,

encouraging and assisting in self-care, maintaining proper body alignment and joint movement. And then the routine therapy services would be subject to the directed payment policy, again, outlined in APL 22-018. Next slide.

Beau Bouchard:

For the exclusive therapy services, so outside of the per-diem rate, some instances where the patient would require therapies that are no longer considered routine are, and these excluded therapy services, would be services that the managed care plans and the SNF providers would negotiate per payment and those are outside of the directed payment.

Beau Bouchard:

For the exclusive services a physician must determine if a patient first requires intensive therapy or therapy beyond the routine or normal course typically provided in order to maintain the highest predictable occupational mental and psychosocial functioning in accordance with their individual plan of care.

Beau Bouchard:

Some examples of exclusive services include many occupational, physical and speech therapies, such as ongoing occupational therapist involvement to conduct periodic assessments of the patient and a physical therapist trains staff on a recipient plan of care that states the beneficiary, such as someone who's suffered a stroke needs hemislings to prevent shoulder subluxation and a hand splint to prevent muscle contracture and deformity in the hand, speech therapy for a post-stroke patient.

Beau Bouchard:

Further details regarding exclusive services not covered under the per-diem rate are available at the TAR criteria, which is in the link covered in the slide. Next slide. So we'll move to the Q and A portion and I'll hand that back over to Kristen to facilitate.

Kristin Mendoza-Nguyen:

Great, thank you Beau. So we have about 10 minutes for questions. There were a couple that came in the chat. I know we responded to a few, I think there was a question just about the materials, so we re-shared that link. But any other questions on the content Bambi presented on APL requirements, or that Tracy presented on PASRR, or for Beau on payments? I'll give it a few minutes. I know folks might still be thinking.

Kristin Mendoza-Nguyen:

Okay. We do have another Q and A at the end so we'll still have some extra time there. Let's see. There is a question from Diana. They submitted a Medi-Cal TAR start date from September of 2022 with the end date of August 2024, but the case worker modified it to the end date to be January of 2023. Is this not part of continuity of care for LTC billing requirements? Might be a question either for Bambi to help weigh in on, or others?

Dana Durham:

Can you repeat the question, Kristin? Sorry.

Kristin Mendoza-Nguyen:

Yeah, it was submitted in the chat from Diana. So there was a submitted Medi-Cal TAR start date that started in September of 2022 with the end date of August 2024, but the case worker modified it to the end date of January 2023. Is this not part of continuity of care?

Dana Durham:

So, we'd have to see the details. That's a good question. I'd want to know a little bit more of the details about it. The TAR would be honored for 90 days if it's not for the skilled nursing facility. If it's for the skilled nursing facility, it could be honored up to a year past that point. The individual would need to go through the regular continuity of care request, and it is different for the billing requirements. So as you're working with plans, there's a difference between having an approved authorization, which is like a TAR, and actually having the correct billing information. So the two are a little different. I hope I answered your question Diana, but please put something in the chat if I did not.

Kristin Mendoza-Nguyen:

Okay. Thank you, Dana. Question from John in the chat. Are TARs still required if the MCP doesn't require it for their authorization process?

Dana Durham:

You would follow the managed care plan's authorization process.

Kristin Mendoza-Nguyen:

Any other questions? All right, I'm not seeing items come in the chat, but we will have a Q and A at the end. So I'm going to go ahead and transition over to our next topic, and I'll hand it over to Laura to talk about Population Health Management.

Dr. Laura Miller:

Great. Thank you so much and welcome to everybody. I'm going to be talking about additions made to the APL around Population Health Management. And just an aside, or not an aside, a central point, Population Health Management is an integral component of CalAIM, and it's really about trying to have high quality services across the board for all members, especially highly vulnerable members.

Dr. Laura Miller:

Next slide. So, the Population Health Management requirement section was edited to add information and requirements about Transitional Care Services. And, of course, this is when a patient or member is transitioning from one setting to another. And as part of their PHM program, MCPs must provide Transitional Care Services, and these will be implemented in a phased approach starting in 2023. So, it’s already in action.

Dr. Laura Miller:

Effective January one of this year, MCPs must implement timely prior authorizations for all members and know when all members are being admitted, discharged, or transferred from facilities, including SNFs. And MCPs must ensure that all transitional care services are completed for high-risk members. High-risk members include members receiving long-term services and supports, LTSS, including SNF services.

Dr. Laura Miller:

A key component, excuse me, of transitional care services is assigning a single point of contact, referred to as a care manager, to assist members throughout their transition and make sure that all required services are complete. We know that times of transitions are times of error where the patient is in a more fragile state, where items can be dropped and the consequences are high. So good, clear holding around transitions are incredibly important. So in 2023, these will be high-risk members who are receiving transitional care services. By January 1st, 2024 plans must ensure that all transitional care services are completed for all members.

Dr. Laura Miller:

Next slide please. So this is an overview of transitional care services. I may have alluded to some of this before, but a care transition is defined as when a member transfers from one setting or level of care to another. This includes, but is not limited to, discharges from hospitals, institutions, other acute care facilities and skilled nursing facilities going to home or community-based settings. Also including post-acute settings or other long-term care settings. So really any time a person changes from one care setting to another or to home, that is a care transition and that is where we need to be very supportive of the member and all their needs.

Dr. Laura Miller:

The goals for transitional care are that a member can transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner and without interruptions in care. The goal is that the member receives the needed support and coordination to have a safe and secure transition with the least possible burden on the member. And that members continue to have the needed support and connections to services that make them successful in their new environment. All incredibly important for those of us who care for human beings.

Dr. Laura Miller:

Next slide please. This slide is a breakdown of what exactly the requirements are for transitional care and who is responsible. So on the top, you have the plan responsibilities, the Medi-Cal MCP, Managed Care Plan responsibilities. They need to know when a member is admitted, discharged or transferred. They need to process authorizations in a timely manner. And they need to notify the care manager. That is the one connector person who's going to assist that member, connect all the dots through that transition.

Dr. Laura Miller:

So, the bottom four pieces are the care manager responsibilities. And this function could live at the plan, could also live at the provider level. And the most important part is that it happens. So the elements of this portion are the discharge risk assessment. And that really is looking at the patient, at their state, what their abilities and disabilities are, coordinating with the discharging facility, where the patient is, and making sure that the destination that the patient is going to makes sense. Will their needs be able to be met? Is it the least restrictive? Does it fit their needs and desires? So, that's the discharge risk assessment.

Dr. Laura Miller:

There's also information sharing and discharge planning. So this is a document that talks about what is going on in the hospitalization and what the ultimate destination is. And this is important that it be shared both with the patient, the primary care provider, and other providers. Then there's follow-up. Very important to make sure that when a patient is discharged from a facility, they have appointments set up with primary care or specialty care, that medication reconciliation happens, and that any referrals are closed.

Dr. Laura Miller:

I know that in my clinic we say, medication reconciliation is life. Life is medication reconciliation. Truly, to know exactly what a patient is on is utterly, utterly, key to safe and appropriate care. And then assess for other services that might support the patient. And this is, I think, one of the very exciting things about CalAIM and all the new programs we have coming onboard. A patient can be supported better in their homes because of the existence of programs like ECM, Enhanced Care Management, as well as Community Supports. And of course Complex Case Management, CCM, that flows from the plans.

Dr. Laura Miller:

Both those terms, the ECM and the CCM, really indicate that the patient has a dedicated person who is helping them manage their care through our multiple fractured systems. And then Community Supports is, as you probably know, very tangible aid such as medically tailored meals, or housing support, respite. Very, very important programs that have recently come online that can absolutely help a person maintain in the least restrictive setting in the best way possible. Next slide.

Dr. Laura Miller:

And so this is just a rundown of the phased Transitional Care Implementation. So, in January of this year, plans are required to provide transitional care to all high-risk members, including those who receive long-term supportive services, or are in a skilled nursing facility. And, again, this is defined in the Population Health Management Policy Guide. And, again, we've talked about who those high-risk members are.

Dr. Laura Miller:

Plans must implement timely prior authorizations and know when patients are admitted, discharged or transferred for all their members. And then plans must execute a roadmap, a plan to ramp up transitional care services, because by January of '24, plans will be required to ensure transitional care services for all members.

Dr. Laura Miller:

And as is noted in the Policy Guide, plans are strongly encouraged to contract with hospitals, ACOs, PCP groups, or other entities, to provide these transitional care services, particularly for lower, or medium, or rising risk members. Next slide. I believe at this point I transition to Dr. Priya Motz, who will be discussing Quality Monitoring. Thank you, Priya.

Dr. Priya Motz:

Thank you, Laura. And thank you everyone for letting me talk today. And so I'll just be talking a little bit more on the Quality Monitoring aspects of the APL, the updates that were made recently. You can go to the next slide please. And so for one of the requirements that we've placed in the APL is for all our managed care plans to maintain a comprehensive Quality Assurance Performance Improvement Program and for any long-term care services that they provide. And within the QAPI, it really should be comprehensive and have a systematic approach to how it is developed and really have data-driven approaches as well with the goal to maintain and continuously improve safety and quality of nursing homes.

Dr. Priya Motz:

Additionally, it is required that the managed care plans also incorporate a system and have a system in place to be able to collect quality assurance and improvement findings from CDPH. And that should include survey results, any deficiencies, or any site visit findings that may impact the plan's QAPI as well. And then we can go to the next slide.

Dr. Priya Motz:

And so, to further detail out what the QAPI program should include, it really should, as mentioned earlier, it should be comprehensive. And at minimum it should include, it should incorporate the contracted skilled nursing facility's QAPI programs that they do as well. And within those programs it should include the five key elements that CMS has identified.

Dr. Priya Motz:

And those five key elements are, and I can drop it in the chat as well for easy visibility as well, but includes a detailed description of elements that include design scope, governance, leadership, as well as feedback data systems monitoring, performance improvement projects, and systematic analysis, and systematic action. And so incorporating those into their QAPI as well.

Dr. Priya Motz:

Additionally, at minimum, they should include claims data for their residents, Medi-Cal members that are part of that SNF. And include, but not limited to, emergency room visits, healthcare associated infections requiring hospitalizations, potentially preventable admissions as well.

Dr. Priya Motz:

And as well as any DHCS-supplied WQIP data through a template provided by us, as well on a quarterly basis. Additionally, mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including assessment of care between care settings and a comparison of services and supports received with those as set forth in the member's treatment plan and service plan as well.

Dr. Priya Motz:

Additionally, effort supporting member community integration should be incorporated into the program as well. And lastly, any DHCS and CDPH efforts to prevent, detect, and remediate identified critical incidences should also be included and in a manner in the report as well. And with that I'll turn it back over to my colleague, Dr. Miller, to talk a little bit more about the Monitoring and Reporting portion of the APL.

Dr. Laura Miller:

Excellent. Thank you, Priya. So with that said, let's go to the next slide. Okay, so for monitoring and reporting, the managed care plans are required to report on long-term care measures within the Managed Care Accountability Set. So the Managed Care Accountability Set is a set of measures that all plans across the state are required to report on. And in 2023, this is the first year that long-term care measures have been present within the Managed Care Accountability Set.

Dr. Laura Miller:

And I think this is a really important advance, and it actually flows from the fact that long-term care is now carved into the plans. So there is much greater, mutual relation going on between plans and skilled nursing facilities. And it's reflected in this decision to have long-term care measures in this standard set of measures. The plans are required to calculate the rates for the long-term care measures for each skilled nursing facility within their network for each reporting unit.

Dr. Laura Miller:

And then plans will be held to quality and enforcement standards as are noted in the two APLs that are on the screen here, APL 19-017 and APL 22-015. Plans are also required to annually submit the QAPI that Dr. Motz discussed with outcome and trending data as specified by DHCS.

Dr. Laura Miller:

There was brief mention on the other slide to the WQIP. The WQIP is a skilled nursing facility improvement program launched this year with financial incentives to the facilities to improve care. But we've designed it such that there's a dovetail. So those three

measures on MCAS are also part of the WQIP, so that both plans and facilities are going in the same direction, essentially. Next slide. And I think I do transition it off now to our next speaker who's going to be discussing LTSS liaison. Thank you so much.

Tracy Meeker:

Thanks Laura. And lastly here, we will review the managed care plan requirement for formalizing an LTSS liaison role, which Bambi alluded to at the beginning of the presentation here. And this section will be included in the APL that will be published next week. So let's go on to the next slide for details.

Tracy Meeker:

Okay, so, a little bit of information of why we're here and why we've come up with this. It's because facilities have reported challenges finding plan staff who understand or are specifically trained in long-term care issues, obtaining authorizations for post-hospital care and timely communication and problem resolution. Therefore, managed care plans must identify either an individual, or individuals, it could be a team, which are either plan staff, or delegated entity staff to serve as liaisons for the LTSS provider community. These staff must be trained by the plan to understand the full spectrum of Medi-Cal Long-Term Institutional Care, including payment and coverage rules.

Tracy Meeker:

The LTSS liaisons must serve as a single point of contact for facilities in both a provider representative role, and to support care transitions as needed. Well, and while we're calling this an LTSS liaison, I know plans could call it different names, it doesn't have to be this name. They could be names such as Provider Relationship Specialists, LTC Specialists, LTSS, or LTC Care or Case Managers. So the intent here is, regardless of what the specific title is, which could change across plans, is that there's a dedicated person or team for the facility to contact when there are issues or questions, or as things come up.

Tracy Meeker:

Next slide please. Okay, so we have three buckets here. The first one is LTSS liaisons must assist facilities in addressing claims and payment inquiries and assist with care transition among the LTSS provider community to best support a member’s needs. In the second box here we talk about LTSS liaisons do not have to be a clinical, licensed professionals, but may be fulfilled with a nonclinical licensed staff member who is trained in the long-term services and supports arena. And finally, managed care plans must identify these individuals and provide their contact information to their network of providers. And I think we'll go to the next slide and I think we're at the Q and A section. So, I will transition back to Kristin to help facilitate.

Kristin Mendoza-Nguyen:

Thank you, Tracy.

Tracy Meeker:

Sure.

Kristin Mendoza-Nguyen:

So opening up for questions for folks who have questions for Dr. Miller, Dr. Motz, or Tracy on the topics presented. Keep an eye on the chat. We didn't see any earlier. Let's see, a question from Lorenzo in the chat, "Is there a new version or a new revision to the SNF LTC policy 22-018 that was published and is revised by DHCS on December 27th of last year? MCP policies for the revision would be due today within 60 days of publishing."

Dr. Priya Motz:

I just, I want to make sure I'm tracking the question correctly. Is this referring more to... So the APL that's published online is the updated version of, and I believe, I think Bambi mentioned that there may be a few tweaks to the APL as well. And in regards to the 60 day for publication? Yes, traditionally all our plans submit a readiness for this APL and they submit the policy procedures for review. And so I believe we're in the midst of reviewing those P&Ps and making sure that they are ready to go to provide these services. But please, let me know if I miss-tracked that or did not track that question appropriately.

Tracy Meeker:

Kristin, it's Tracy. I'll just add that the initial APL was published in September, and just looking online it looks like it was revised, as the requester asked, in December. So this policy that we're talking about here will be issued again. There'll be another update. And the APL number may change, but it will still have the same content.

Kristin Mendoza-Nguyen:

Okay, great. I know Bambi mentioned this earlier on: hopes to be published soon, but yes the APL number will change. Follow up question from Lorenzo, "Do we have to submit updated policies today?"

Bambi Cisneros:

Lorenzo, are you, if I may ask, are you with a plan? I don't know if you could maybe just type in the chat? So, the submission of the policies as a plan requirement is triggered by the APL posting. So some of the new key features that we talked about on today's call are the new requirements. And so it wouldn't be in effect until the APL is posted and then the timeline is triggered.

Lorenzo:

Bambi? Hello. Yeah, here's my question. Today, our updated policies are due today. If the policy is going to- if the APL is going to be updated in a week, it really doesn't make any sense to submit our updated policies today, when we have to change them after something is published again. So my question is, do we have to go through today's, which we're working on now, submitting a policy to DHCS, and then knowing that a new APL is coming out by next week, that we'd have to submit another policy on top of the

policy we just submitted. It doesn't make logical sense for plans to submit a policy today, that's supposed to be reviewed by the DHCS, and then submit another policy and update that policy when we know the APL is going to change. So that's the question.

Bambi Cisneros:

Okay, got it. Thank you for clarifying the question also with a plan. So the requirement that was posted in December is different than what we were talking through today. They were like the QAPI and things, so I don't think there should be overlap, but I do know that plans have their P&Ps set up differently from plan to plan. So if you don't mind sending us an email through the CalDuals inbox at the end of this slide and maybe just let us know what plan you're with. We're happy to take a look at what we have so far. But I think the intent is, really, there should not really be any overlap. So you wouldn't be submitting today, and then again for the same requirement. But we would work with you, Lorenzo. So just let us know your situation, and we're happy to take a look.

Kristin Mendoza-Nguyen:

Okay, great. And then the email address was just put in the chat as well for you. Any other questions? Okay, I'm not seeing questions. So Bambi, I'll turn it to you to just go through the last few slides for Next Steps and to close this out for today.

Bambi Cisneros:

Sure, thank you. So this is our little walk down memory lane. We did have a host of educational webinars, and today is our final one. We talked through in previous webinars Managed Care 101, Skilled Nursing Facility 101, Promising Practices for Contracting, Billing And Payment Rules, and Policy Updates. And we hope that these webinars have been helpful and valuable to you.

Bambi Cisneros:

We did provide the link here, which does link to the materials from those previous webinars and information. And we will keep that on the website so you have that as reference. And then I think we have other links to share too. If you can go on the next slide please? So we have also shared out other resources not tied to the long-term care benefits specifically, but it was more on CalAim's Enhanced Care Management and Community Supports. And so we did provide those links here as well.

Bambi Cisneros:

And we do still have other stakeholder work groups that may touch on duals and other members that are in skilled nursing facilities. And those include the MLTSS and Duals Integration Stakeholder Workgroup meetings. There's also a stakeholder meeting on Nursing Facility Financing Reforms. And we have a separate effort on, part of the umbrella of the long-term care benefit is the ICF, or Intermediate Care Facility Workgroup meetings.

Bambi Cisneros:

And so those are all ongoing and we provided those things here as well. We also shared an email here at the bottom. And so if you are a provider and have been experiencing challenges contacting your managed care plan, you can send an email to the Department here at this MCQMD@DHCS.ca.gov, and we will work on connecting you with the appropriate managed care plan contract.

Bambi Cisneros:

But just wanted to remind folks though that we will do that to facilitate that conversation and dialogue and sharing of contact information. But the Department does not get in the middle between negotiation between managed care plans and their provider contracts including skilled nursing facilities. So just do want to flag what our role is there.

Bambi Cisneros:

And then the very last slide here is just a link to the existing All Plan Letter that we have posted that we are currently revising that we just talked through, as well as FAQs and other resources for the managed care plan. So I just wanted to provide all of the various resources that have been developed for this initiative.

Bambi Cisneros:

And so if there are any follow up questions, we do encourage you to reach out to info@calduals.org, here on this slide. And with that, I think on behalf of the Department, we really want to thank you all for joining on this webinar education series and for all of the speakers from the Department side, thank you as well. We hope you have a good day and weekend. And thank you all for your collaboration and support. Thank you.