CalAIM Skilled Nursing Facility (SNF) Carve-In: Policy Update

DHCS

February 24, 2023

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Meeting Management

- This webinar is being recorded.
- Participants are in listen-only mode.
- Please use the “chat feature” to submit any questions you have for the presenters.
- This webinar will include various Q&A opportunities. Please note that this webinar is focused on the SNF Carve-In and questions specific to the SNF Carve-In will be addressed during the Q&A sessions.

Agenda

Topics	Time
Welcome and Introductions	2:00 – 2:05 PM
SNF Carve-In Post Transition Reminders, Key Policy Requirements, Additions to APL, and Q&A	2:05 – 2:35 PM
Additions to APL (Continued) and Q&A	2:35 – 2:55 PM
Next Steps & Closing	2:55 – 3:00 PM

CalAIM Long-Term Care Skilled Nursing Facility Carve-In Overview

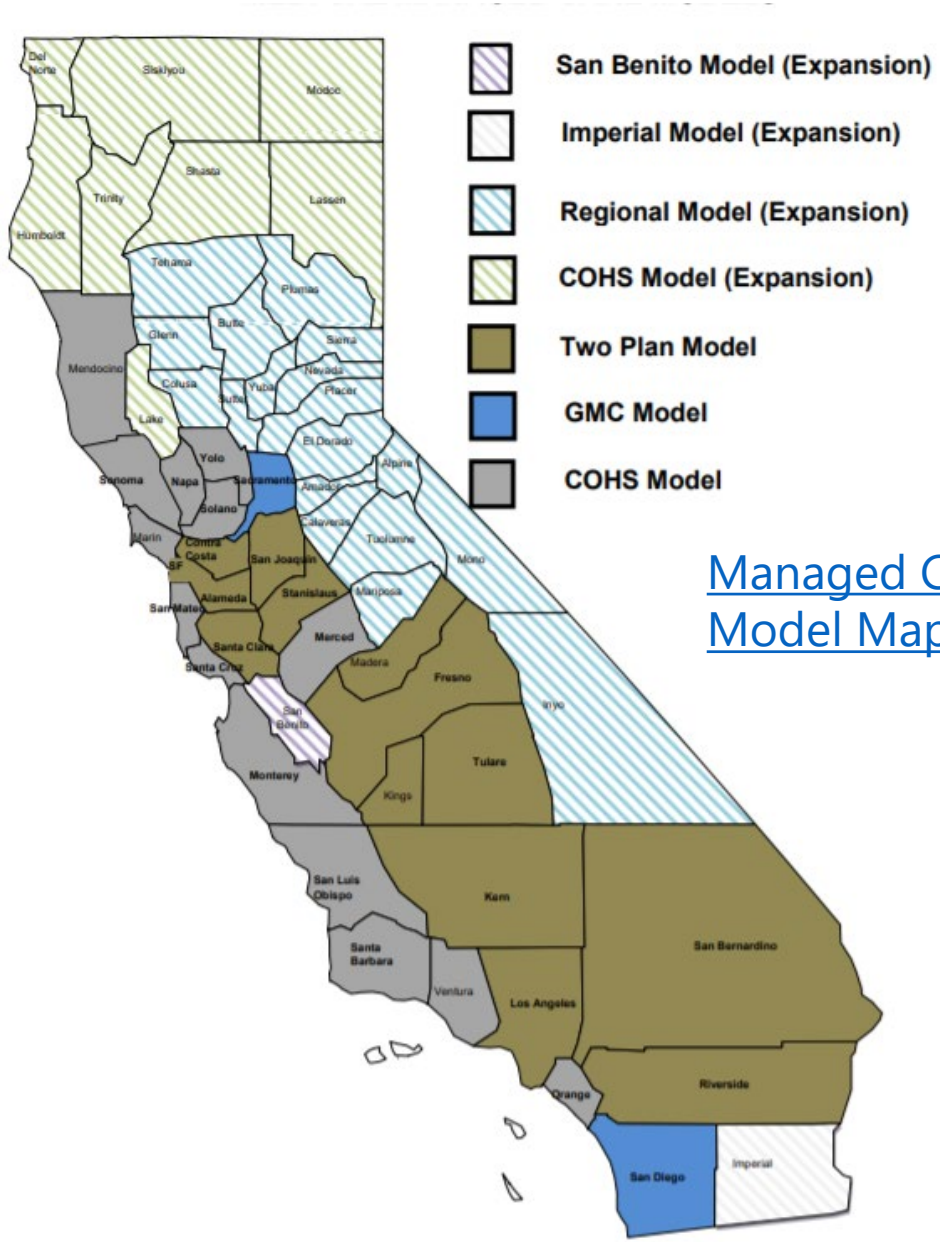
- Effective January 1, 2023, Medi-Cal managed care plans (MCPs) in all counties now cover the LTC benefit for Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital.
- Enrollment in Medi-Cal managed care is mandatory for all Medi-Cal beneficiaries residing in a SNF.

SNF Carve-In Goals

- Standardize SNF services coverage under managed care statewide.
- Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.
- Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal beneficiaries in SNFs.

Medi-Cal Managed Care

- All counties have Medi-Cal MCPs, but the plan models differ by county. To view Health Plan Options by county, see the Medi-Cal Managed Care Health Plan Directory.
  - Additional information about managed care models can be found on the Managed Care Models Fact Sheet.
- DHCS contracts with Medi-Cal MCPs and Medi-Cal MCPs establish a defined network of providers that Medi-Cal MCPs pay directly.
- The overall goal of Medi-Cal managed care is to provide coordinated, high-quality, and cost-effective care.



Managed Care Model Map

Key APL Requirements & Reminders

- Authorizations
- Continuity of Care (CoC)
- Network Adequacy
- Clean Claims

Authorizations

- **Treatment Authorizations Requests (TARs)**
  - MCPs must maintain continuity of care for members in a SNF facility by recognizing any treatment authorization requests for SNF facility services made by DHCS for the member enrolled into the MCP.
  - MCPs are responsible for all other approved TARs for services in a SNF exclusive of the SNF per diem rate for a period of 90 days after enrollment in the MCP, or until the MCP is able to ***reassess*** the member and authorize and connect the member to medically necessary services
- **Service Authorizations**
  - Prior authorization requests for members who are transitioning from an acute care hospital must be considered ***expedited,*** requiring a response time no greater than 72 hours, ***including weekends***.

Authorizations (Cont'd)

- **Expedited authorizations:**
  - The 72-hour time period is inclusive of any time outside normal business hours, including weekends and after hours.
  - For example, if a request is received at 4:30pm on a Thursday, a notice would have to be received by 4:30pm on Saturday.
  - If an expedited authorization does not receive a response within this 72 hours time period, you may file a complaint through the MCP's Grievance Process.

For more information on this process, see APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates

Continuity of Care – SNF Services

- Effective January 1, 2023, through June 30, 2023, for members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, MCPs must automatically provide 12 months of continuity of care for the SNF placement. members do not have to request to remain in their current facility.
- MCPs must provide Continuity of Care (CoC) for all medically necessary LTC services at non-contracting LTC facilities for members residing in a SNF at the time of enrollment.
- To prevent disruptions in care, members must be allowed to stay in their current SNF residence, as long as:
  - The facility is licensed by the California Department of Public Health (CDPH);
  - The facility meets acceptable quality standards, including the MCP's professional standards; and
  - The facility and MCP must agree to work together.

Continuity of Care – Providers

- Under CoC, members may continue seeing their out-of-network Medi-Cal providers for up to 12 months.
  - The member, authorized representative, or provider contacts the new MCP to make the request.
  - The member can validate that they have seen the provider for at least one non-emergency visit in the prior 12 months.
  - The provider meets the MCP's professional standards and has no disqualifying quality of care issues.
  - The provider is willing to work with the MCP (i.e., agree on payment and/or rates).
- Members entering managed care residing in a SNF after June 30, 2023, **will not** receive automatic CoC and must request CoC.

Continuity of Care – Other Services

- **Other Services:** CoC provides continued access to the following services, although could require a switch to in-network providers.
  - Durable Medical Equipment Rentals and Medical Supplies
  - Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
  - Facility Services
  - Professional Services
  - Select Ancillary Services
  - Appropriate level of care coordination

Network Adequacy

- As part of Plan Readiness, DHCS established network readiness requirements in APL; specifically, that MCPs must:
  - Attempt to contract with all SNFs in the MCP's service area; and
  - Contract with a minimum of 60% of SNFs.
- DHCS encourages MCPs to contract broadly with all CDPH enrolled and licensed SNFs.
- Letters of Agreements (LOA) should only be used during the interim while contracts are in progress.
- MCPs should seek to replace the LOAs with network provider agreements.

Clean Claims

- MCPs have reported issues with facilities being able to submit clean claims in a timely manner.
- MCP and DHCS contracts specifies that the MCP shall pay 90 percent of all clean claims from Providers, within 30 calendar days of the date of receipt, and 99 percent of all clean claims from Providers' claims, within 90 calendar days of the date of receipt.
- MCPs and SNFs are required to work collaboratively to ensure an alignment in understanding claims requirements and the submission process.

- SNFs need outreach, education, and support from MCPs to understand how to submit clean claims and meet clean claims requirements.

Additional Tips and Resources for Billing

- Additional tips for billing and common billing errors
- LTC Claim Form and Code Conversion: https://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa_ltc_home.aspx
- LTC Code and Claim Form Conversion FAQs: https://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa_ltc_faq.aspx
  - LTC 25-1 to UB-04
  - Accommodation, Revenue, Value Codes Crosswalk
  - Patient Status Code and Discharge Code Crosswalk
- Balance Billing: https://www.dhcs.ca.gov/individuals/Pages/Balanced-Billing.aspx

Additions to APL: The Preadmission Screening and Resident Review (PASRR)

The Preadmission Screening and Resident Review (PASRR)

- PASRR is a federal requirement (42 CFR 483.100-138) to help ensure that individuals are not inappropriately placed in nursing homes for long term care.
- The 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/developmental disability or related conditions
- MCPs are required to work with DHCS and Network Providers, including discharging facilities or admitting nursing facilities, to obtain documentation validating PASRR process completions.

About PASRR

- The purpose is to determine if individuals with serious mental illness (SMI) and/or intellectual/developmental disability (ID/DD) or related conditions require:
  - Nursing facility services, considering the least restrictive setting
  - Specialized services
- Achieved by the PASRR process, which consists of a Level I Screening, Level II Evaluation, and a final Determination.

For more information: https://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx

Additions to APL: Facility Payment

Facility Payment: Directed Payment Policy

- MCPs in counties where ***extended*** coverage of SNF services is ***newly transitioning*** from the FFS delivery system to the managed care delivery system, must reimburse Network Providers of SNF services for those services at **exactly the Medi-Cal FFS per-diem rates** applicable to that particular type of institutional LTC provider.
- MCPs in counties where ***extended*** SNF services were *already* Medi-Cal managed care Covered Services must reimburse Network Providers of SNF services for those services at **no less than the Medi-Cal FFS per-diem rates** applicable to that particular type of institutional LTC provider.

This requirement applies only to:

- SNF services as set forth in 22 CCR § 51123(a) to include:
  - Room and board
  - Nursing and related care services
  - Commonly used items of equipment, supplies, and services as set forth in 22 CCR § 51511(b)
    - Leave of absence days as set forth in 22 CCR § 51535
    - Bed holds as set forth in 22 CCR § 51535.1

Facility Payment

- Medi-Cal FFS per-diem rates for SNF services are all-inclusive rates that account for both skilled and custodial levels of care and are not tiered according to the level of care.
- Ancillary services are excluded from the services bundled under the Medi-Cal FFS per-diem rates.
- The reimbursement requirement **does not** apply to any other services provided to a Member receiving SNF services such as, but not limited to, services outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d), 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 of this State directed payment and are payable by MCPs in accordance with the terms negotiated between the MCP and the Provider.
  - The reimbursement requirement does not govern payments not directly for SNF services rendered, such as, but not limited to, provider incentive and pay-for-performance payments.

Per Diem Rate: Inclusive Therapy Services

- Per the Medi-Cal Provider Manual, many routine services needed to attain and/or maintain the highest practicable level of functioning can and should be performed as part of the per diem rate—and thus are ***included*** under the directed payment. Examples include:
  - Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
  - Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
  - Changing position of bedfast and chairfast recipients
  - Encouraging and assisting in self-care and activities of daily living
  - Maintaining proper body alignment and joint movement to prevent contractures and deformities
- Additional Information: Medi-Cal Provider Manual: LTC Inclusive and Exclusive Services

Per Diem Rate: Exclusive Therapy Services

- Medi-Cal MCPs and SNFs can negotiate payment for other therapy services that are outside of the directed payment rate.
- For excluded services, a physician must determine if a patient requires intensive therapy (beyond the normal course typically provided to SNF residents) to attain or maintain the highest practicable occupational, mental, and psychosocial functioning in accordance with their individualized plan of care.
- Excluded services includes many occupational, physical, and speech therapies such as:
  - Ongoing occupational therapist involvement to conduct periodic assessments of the patient and evaluation of the patient-specific treatment plan.
  - A physical therapist trains staff on a recipient plan of care that states the beneficiary (who has 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 poststroke patient who is dysphasic.
- Further details regarding exclusive services not covered under the per diem rate are available at TAR Criteria for NF Authorization (Valdivia v. Coye)

Questions?

APL Requirements, PASRR, Facility Payment

Additions to APL: Population Health Management

Population Health Management: Transitional Care Services (TCS)

- As part of their PHM Program, MCPs must provide strengthened TCS that will be implemented in a phased approach starting in 2023.
- Effective January 1, 2023:
  - MCPs must implement timely prior authorizations for all members and know when all members are admitted, discharged, or transferred from facilities, including SNFs.
  - MCPs must ensure that all TCS are completed for all high-risk members. High-risk members include members receiving long-term services and supports (LTSS), including SNF services.

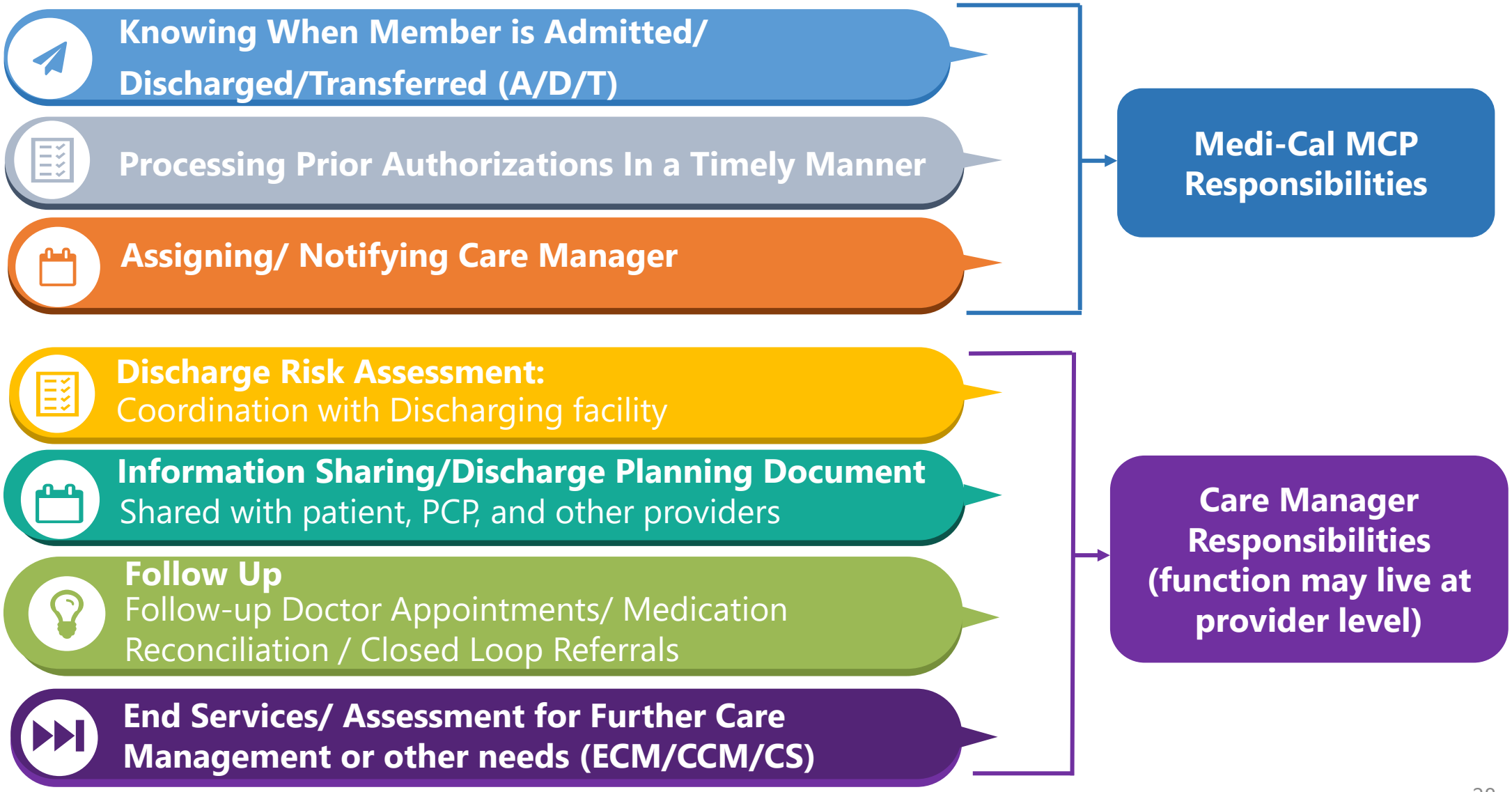
Overview of Transitional Care Services

Care Transitions Definition:
When a member transfers from one setting or level of care to another, including but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home or community-based settings, Community Supports, post-acute care facilities, or long-term care settings.

Goals for Transitional Care

- ✓ Members can transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.
- ✓ Members receive the needed support and coordination to have a safe and secure transition with the least burden on the Member as possible.
- ✓ Members continue to have the needed support and connections to services that make them successful in their new environment.

Medi-Cal MCP PHM Requirements on Transitional Care Services



New Policy Guidance on Phased Transitional Care Implementation

Starting on 1/1/23, Medi-Cal MCPs will be required to provide transitional care services to all high-risk members, including those who receive LTSS or are in a SNF.

Formal Guidance on Phased Implementation of Transitional Care Services	
By 1/1/23	• Medi-Cal MCPs must ensure **all transitional care services are complete (including having a care manager/single point of contact) for all high-risk members**[1] as defined in the PHM Policy Guide. • Medi-Cal MCPs must implement **timely prior authorizations** and **know when members are admitted, discharged or transferred for all members.** • Medi-Cal MCPs must develop and **execute a plan to ramp up** transitional care services. The plan must address how the Medi-Cal MCPs will meet the timeline and requirements.
By 1/1/24	• Medi-Cal MCPs are required to ensure **all transitional care services are complete for all members**. As noted in the PHM Policy Guide, Medi-Cal MCPs are strongly encouraged to contract with hospitals, Accountable Care Organizations, PCP groups, or other entities to provide transitional care services, particularly for lower- and medium-rising- risk members.

1. High risk members are defined as any population listed under Section D. Understanding Risk, 2) Assessment to Understand Member Needs Section of the PHM Policy Guide, including but not limited to: any "high risk" members as identified through the Medi-Cal MCPs' Risk Stratification and Segmentation (RSS) mechanisms or through the PHM Service once the statewide RSS and risk tiers are available; any other populations who require assessments, such as those in ECM or CCM, those who received LTSS, Children with Special Health Care Needs (CSHCN), Pregnant Individuals, Seniors and Persons with disabilities who meet the definition of "high risk" as established in existing APL requirements, etc.

Additions to APL: MCP Quality Monitoring

MCP Quality Monitoring

- MCPs are responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for long term care services provided.
  - QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes.
- MCPs must have a system in place to collect quality assurance and improvement findings from CDPH to including survey deficiency results, site visit findings, and complaint findings.

QAPI Program

- MCP's comprehensive QAPI program must incorporate:
  - Contracted SNFs' QAPI programs, which should include five key elements identified by CMS.
  - Claims data for SNF residents, including but not limited to emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions as well as DHCS supplied WQIP data via a template provided by DHCS on a quarterly basis.
  - 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 set forth in the Member's treatment/service plan.
  - Efforts supporting Member community integration.
  - DHCS and CDPH efforts to prevent detect, and remediate identified critical incidents.

Additions to APL: Monitoring & Reporting

Monitoring and Reporting

- MCPs are required to report on LTC measures within the Managed Care Accountability Set (MCAS) of performance measures.
- MCPs are required to calculate rates for each MCAS LTC measure for each SNF within their network for each reporting unit.
- MCPs will be held to quality and enforcement standards in APL 19-017 and APL 22-015.
- MCPs are also require to annually submit QAPI program reports with outcome and trending data as specified by DHCS.

Additions to APL: LTSS Liaison

LTSS Liaison

- MCPs must identify an individual or individuals (either plan staff or delegated entity staff) to serve as liaisons for the LTSS provider community.

MCPs to establish and formalize an LTSS Liaison role (single point of contact MCP for SNFs) that are:

- Trained to understand the full spectrum of Medi-Cal long-term institutional care, including payment and coverage rules
- Serve as a single point of contact for facilities in both a provider representative role and to support care transitions, as needed

LTSS Liaison

The MCP LTSS liaison must assist facilities in addressing claims and payment inquiries.

The MCP LTSS liaison must assist with care transitions among the LTSS provider community to best support the Member's needs.

MCPs must identify these individuals and provide their contact information to their network of providers.

Questions?

Transitional Care Services, MCP Quality Monitoring, Monitoring & Reporting, LTSS Liaison

Skilled Nursing Facility Carve-In Webinars

SNF Carve-In Policy Update	**Medi-Cal Managed Care and Skilled Nursing Facility Residents**	**LTC Billing and Payment Rules**
Promising Practices for Contracting	**CalAIM LTC Statewide Carve-In 101 for SNFs**	**CalAIM LTC SNF Carve-In 101 for MCPs**

Materials from previous webinars and information on the SNF Carve-In can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx

Other DHCS Workgroup or Stakeholder Meetings

- Updates on the long-term care can be found in other DHCS stakeholder meetings, including:
  - MLTSS and Duals Integration Stakeholder Workgroup
  - Nursing Facility Financing Reform (AB 186) Stakeholder Meetings
  - ICF/DD Workgroup Meetings
- DHCS Resources:
  - Factsheet on Enhanced Care Management
  - Factsheet on Community Supports
  - Outreach Information about Medicare Medi-Cal Plans

If you are a provider and have been experiencing challenges contacting your MCP(s), you may send an email to DHCS at MCQMD@dhcs.ca.gov and we can work to connect you with the appropriate MCP contact.

Resources and Contact Information

Questions? Please contact info@calduals.org

- APL 22-018 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- CalAIM SNF LTC Carve-In Resources for Medi-Cal MCPs
- Frequently Asked Questions (FAQs)

- DHCS Resources
  - Long-Term Care Carve-In Transition: https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx
  - CalAIM: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx
  - Integrated Care for Dual Eligible Beneficiaries: https://www.dhcs.ca.gov/services/Pages/Integrated-Care-for-Dual-Eligible-Beneficiaries.aspx

Thank you!

Appendix

Appendix A: Per Diem Rate & Billing

Per Diem Rate: Included SNF Services

- Rates for LTC facilities include all supplies, drugs, equipment and services necessary to provide a designated level of care. Other inclusive items include:
  - Room and board
  - Nursing and related care services
  - Commonly used items of equipment, supplies, and services (e.g. personal hygiene items)
  - Routine therapy services
  - Leave of absence days and bed holds
- Medi-Cal MCPs are obligated to pay for all SNF levels of care, including custodial care, skilled nursing facility care (NF-B), and intermediate care (NF-A).
- Additional Information: Medi-Cal Provider Manual: LTC Inclusive and Exclusive Services

Per Diem Rate: Exclusive SNF Services

- **Services outside the per-diem rate** are not subject to the Directed Payment policy and would follow the Medi-Cal MCP and providers normal negotiation process.
- These exclusive items are separately reimbursable and subject to the utilization review controls and limitations of the Medi-Cal program.
- Exclusive items (not included in the per diem rate) include supplies, drugs, equipment or services such as:
  - Durable Medical Equipment as specified in CCR, Title 22, Section 51321(g) and (h)
  - Laboratory services and X-rays
  - Dental services
- Medi-Cal Provider Manual: LTC Inclusive and Exclusive Services and excluded items are outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d).

Tips for Billing

- SNFs and LTC providers should validate billing codes with MCPs to ensure the appropriate codes are being utilized to ensure a clean claim.
- For Bed Holds, check regularly for recipients on leave at home, at an acute hospital, or transferred to another LTC facility.
- Verify that dates of service on the claim reflects only the dates for services rendered and verify that the dates of service on the claim match the approved dates within the TAR and/or authorization (e.g., if dates do not match a reauthorization may be required)
- Verify that the facility to which the recipient was transferred is billed correctly.
- For dual beneficiaries, bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements. Submit claim to the California MMIS Fiscal Intermediary within 60 days of Medicare or OHC carrier's resolution. Use the OHC Explanation of Benefits date or Medicare Remittance Advice date to calculate timeliness.
- Confirm that the patient status code agrees with the accommodation code. For example, if the status code indicates leave days, the accommodation code must also indicate leave days.

Appendix B: Continuous Coverage Unwinding

Continuous Coverage Unwinding

- **The continuous coverage requirement will end on March 31, 2023 and Medi-Cal beneficiaries may lose their coverage.**
- **Medi-Cal redeterminations will begin on April 1, 2023 for individuals with a June 2023 renewal month.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available
  - Check out the Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan (Updated January 13, 2023)!

Continuous Coverage Unwinding Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Already launched**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch approximately 60 days prior to termination of the Continuous Coverage requirement.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.