CalAIM Skilled Nursing Facility (SNF) Carve-In: How Medi-Cal Managed Care Supports SNF Residents

DHCS

January 30, 2023

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  - For example: Kristin Mendoza-Nguyen – Aurrera Health Group

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
Medi-Cal Managed Care Benefits Review and Q&A	2:05 – 2:35 PM
Medi-Cal Managed Care Benefits Review (Continued) and Q&A	2:35 – 2:58 PM
Next Steps & Closing	2:58 – 3:00 PM

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

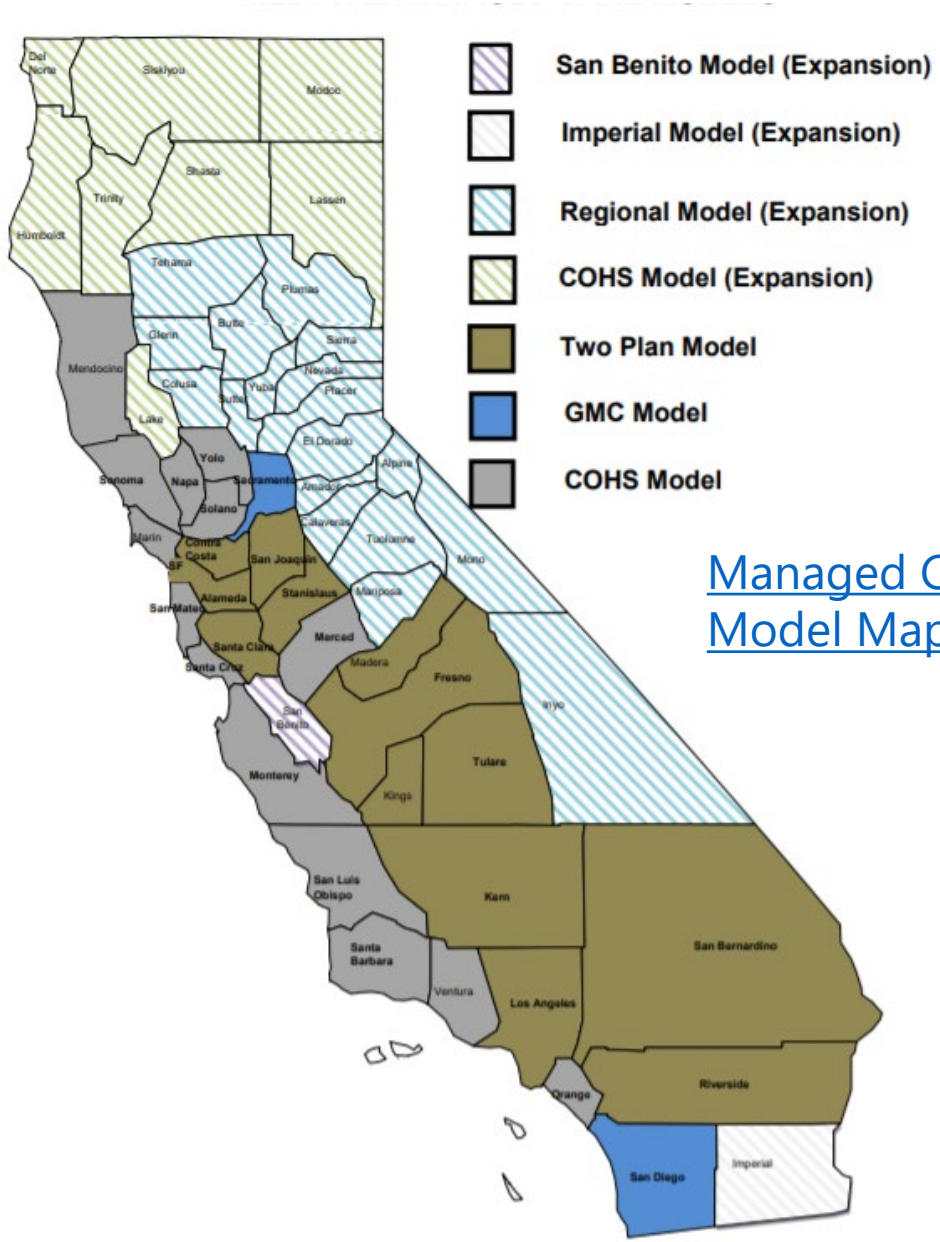
- Effective January 1, 2023, Medi-Cal managed care plans (MCPs) in all counties now cover the LTC benefit for Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital.
- Enrollment in Medi-Cal managed care is mandatory for all Medi-Cal beneficiaries residing in a SNF.

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 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

Medi-Cal Managed Care Key Benefits

Basic Population Health Management (BPHM)	**Complex Care Management (CCM)**	**Enhanced Care Management (ECM)**	**Transitional Care Services (TCS)**
Dual Eligible Member Care Coordination	**Community Supports**	**Transportation**	**LTC Services: Inclusive and Exclusive**

Population Health Management Program Overview

DHCS is establishing a standardized, statewide approach to PHM through which Medi-Cal Managed Care Plans (MCPs) are responsive to community needs and work within a common framework to improve outcomes and reduce disparities.

PHM Program Overview

- A cornerstone of CalAIM includes the expectation that starting in 2023, each Medi-Cal MCP will **have and maintain a whole system, person centered Population Health Management** (PHM) program.
- Many of the **key elements of PHM are already in place** in Medi-Cal through both Department of Health Care Services (DHCS) policies and each Medi-Cal MCPs' population health management programs.
- **The PHM Program is a cohesive set of concepts and requirements that apply to all populations served by Medi-Cal MCPs**.

Beginning in 2023, all Medi-Cal MCPs will be required to meet National Committee for Quality Assurance (NCQA) PHM standards.

PHM requirements will be phased in, and DHCS will **roll out new PHM requirements gradually between 2023 and 2024**.

CalAIM Care Management Continuum

In 2023, Medi-Cal managed care plans (MCPs) are required to have a broad range of programs and services to meet the needs of all members organized into the following three areas.

Enhanced Care Management (ECM) is for the **highest-need members** and provides intensive coordination of health and health-related services.

Complex Care Management (CCM) is for members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.

Basic Population Health Management (BPHM). BPHM is the array of programs and services for **all** Medi-Cal MCP members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

Transitional Care Services are supports and services for members transferring from one setting or level of care to another.

For more information on the CalAIM Care Management continuum, see the PHM Policy Guide

Basic Population Health Management (BPHM)

Overview of BPHM

BPHM means an approach to care that ensures needed programs and supports are made available to each Member, at the right time and in the right setting to address their health and health-related needs.

BPHM Defined

The Key components of BPHM include:

- Access, utilization and engagement with primary care
- Care coordination and referrals to all health and social services
- Information sharing and referral infrastructure
- Integration of Community Health Workers (CHW)
- Wellness and prevention programs
- Programs addressing chronic disease
- Program to address maternal health outcomes
- PHM for children, including ensuring Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for all children and youth

Health education and cultural & linguistic (C&L) programs and resources, along with linkages to public health, schools, and social service programs, are foundational for the effective delivery of BPHM.

The components of BPHM are not new, and many are included in NCQA PHM standards; however, DHCS has not previously articulated them as a comprehensive a package of programs and supports.

Complex Care Management (CCM)

Overview of Complex Care Management

DHCS is establishing common terminology and set of expectations that apply across populations who need care management, establishing a continuum between care management approaches, including CCM and ECM.

Complex Care Management

- Equates to "Complex Case Management" as defined by NCQA.
- For both higher and medium/rising-risk Members.
- Includes chronic care management and interventions for episodic, temporary needs.
- Must include comprehensive assessment and adhere to all NCQA PHM CCM requirements.
- Medi-Cal MCPs may use their own staff as care managers.

Enhanced Care Management (ECM)

What is ECM?

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

- ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home
- ECM is part of broader CalAIM Population Health Management system design through which Medi-Cal MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level

For more details, see ECM Policy Guide (December 2022).

Seven ECM Core Services

Outreach and Engagement

Member and Family Supports

Comprehensive Assessment and Care Management Plan

Health Promotion

Enhanced Coordination of Care

Comprehensive Transitional Care

Coordination of and Referral to Community and Social Support Services

Adults Living in the Community Who Are At Risk for LTC Institutionalization

Population of Focus Definition

Definition
(1) Adults living in the community who meet the Skilled Nursing Facility (SNF) Level of Care criteria;[1] **OR** who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;[2] **AND** (2) are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring),[3] **AND** (3) are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

For more details, see ECM Policy Guide (May 2022).

Adults Living in the Community Who Are At Risk for LTC Institutionalization

Population of Focus Definition - Continued

Notes on the Definition:

- **Living in the Community:** Members who meet this Population of Focus may live in independent housing, Residential Care Facilities, Residential Care Facilities for the Elderly (RCFEs), or any other dwelling that meets the requirements established in the Home and Community Based Services (HCBS) Settings Final Rule.[4]
- **Exclusions:** Adults living in the community who are at risk of institutionalization into Intermediate Care Facilities (ICF) and subacute care facilities are excluded from this Population of Focus.

1. As established in the California Code of Regulations 51335: Link
2. Criteria adapted from the 2020 Medi-Cal Long-Term Care At Home proposal: Link
3. Criteria adapted from the Community-Based Health Home eligibility criteria: Link
4. CMS Final Rule 79 FR 2947, Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; 42 CFR 441.301(c)(4) and (5)

For more details, see ECM Policy Guide (May 2022).

Nursing Facility Residents Transitioning to the Community

Population of Focus Definition

Definition
Nursing facility residents who are: » Interested in moving out of the institution; » Are likely candidates to do so successfully; and » Able to reside continuously in the community.

Notes on the definition:

» **Able to Reside Continuously in the Community**: Members transitioning to the community may need to return to the hospital or SNF intermittently for short admissions (potentially due to changes in medical conditions or other acute episodes). They should not be precluded from being considered able to reside continuously in the community.

» **Exclusions**: Individuals residing in Intermediate Care Facilities (ICF) and subacute care facilities are excluded from this Population of Focus.

For more details, see ECM Policy Guide (May 2022).

How Do Qualified Members Access the ECM Benefit?

- **Members who qualify may be contacted directly by their health plan and/or a Community Supports provider.** Medi-Cal health plans are responsible for regularly identifying Members who may benefit from ECM and who meet the criteria (e.g., Population of Focus). Once a Member is identified, the health plan and/or their assigned ECM provider will contact them to discuss ECM.
- **A health and social services provider, such as an ECM provider, may submit a referral for members.** If a Member has not yet been identified by the Medi-Cal health plan as eligible for ECM, but appears to meet the requirements, their provider(s) can submit a referral to the Member's health plan. The health plan is required to have a referral process that is available for health and social service providers. You do not need to be a clinician to refer someone to ECM.
- **Members may self-refer or ask for information to see if they qualify.** A Member or the Member's family can contact their Medi-Cal health plan to see if they qualify for Enhanced Care Management. Members can contact their health plan by calling the number on the back of their insurance card.

Transitional Care Services (TCS)

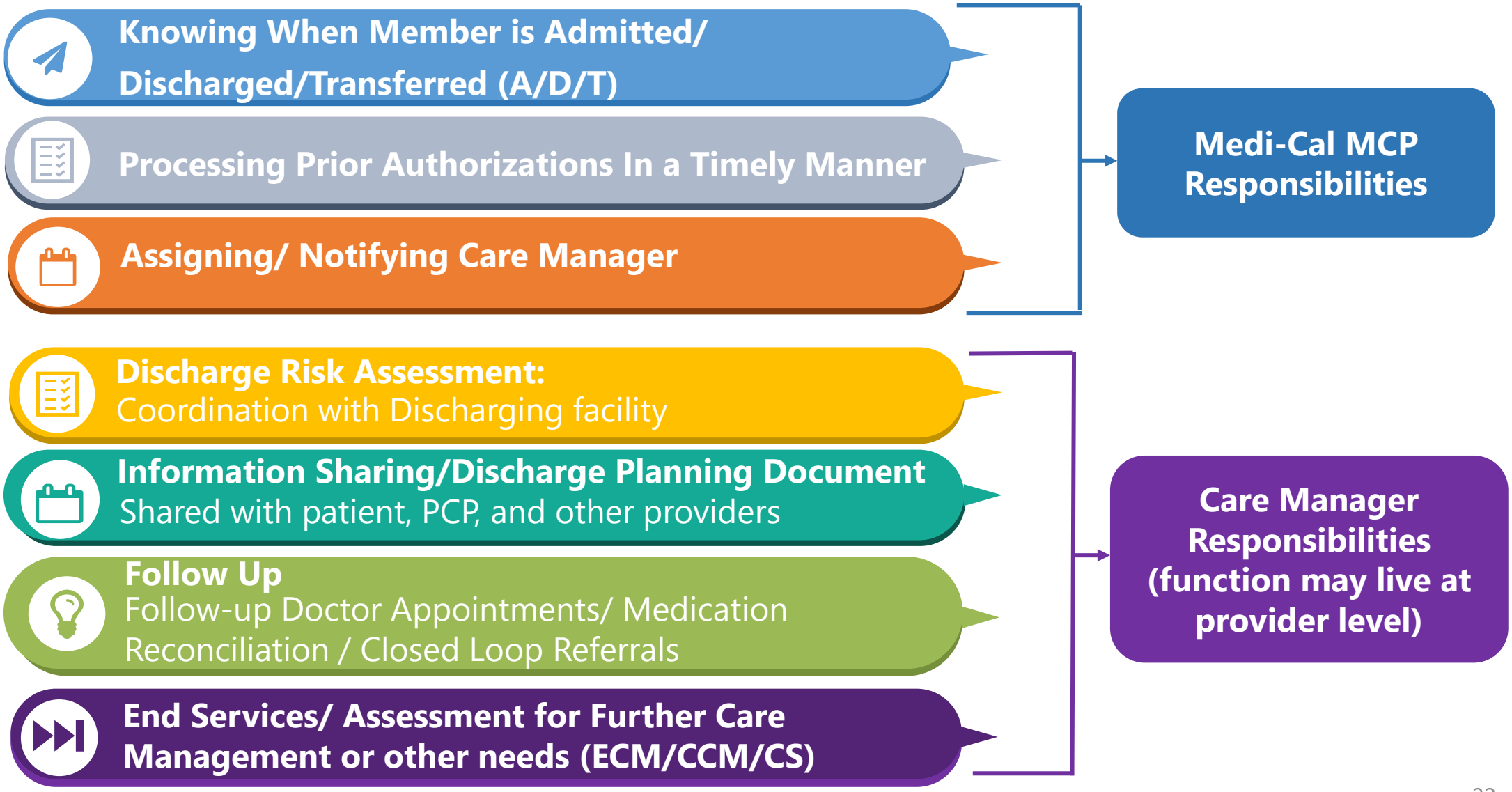
Overview of Transitional Care Services

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.

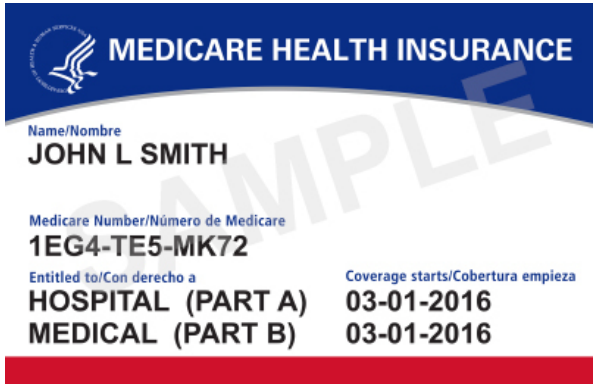
Formal Guidance on Phased Implementation of Transitional Care Services	
By 1/1/23	• Medi-Cal MCPs must ensure **all transitional care services are complete (including having a care manager/single point of contact) for all high-risk members**[1] as defined in the PHM Policy Guide. • Medi-Cal MCPs must 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.

Care Coordination for Dual Eligible Beneficiaries in Medicare Medi-Cal Plan (MMP)

Medicare, Medi-Cal, and the Need for Coordinated Care

- Dual eligible beneficiaries are individuals eligible for both Medicare and Medi-Cal, often referred to as Medi-Medis.
- The majority of beneficiaries residing in SNFs are dual eligible individuals.
- For most dual eligible beneficiaries, Medicare and Medi-Cal operate separately and with different funding streams.
- For dual eligible beneficiaries with high rates of chronic conditions and functional impairments, streamlined access to services across health and long-term services and supports (LTSS) systems is critical.



Cal MediConnect Transition

- Cal MediConnect Plans were health plans for dual eligible beneficiaries that combined Medicare and Medi-Cal benefits with additional care coordination. They were available in seven counties (known as Coordinated Care Initiative, or CCI, counties).
- Cal MediConnect ended on **December 31, 2022**. On **January 1, 2023**, beneficiaries in Cal MediConnect plans were automatically transitioned into a **Medicare Medi-Cal Plan (MMP or Medi-Medi Plan)** operated by the same parent company as the Cal MediConnect plan.

Medicare Medi-Cal Plans

- Medi-Medi Plans, also known as Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs), are a type of Medicare Advantage plan in California that are only available to dual eligible beneficiaries, and build and expand on the benefits of Cal MediConnect.
- Beneficiaries enrolled in a Medi-Medi Plan receive their Medicare benefits through a D-SNP and their Medi-Cal benefits through a Medi-Cal managed care plan, similar .
  - D-SNPs (a type of Medicare Advantage plan) provide Medicare Part A, B, and D services (hospitals, providers, and prescription drugs) in addition to specialized care for dual eligible beneficiaries also enrolled in the matching Medi-Cal plan.
  - Medi-Cal plans provide wrap-around services, including Medicare cost-sharing, Long-Term Services and Supports (LTSS), and durable medical equipment (DME).
- Both are operated by the same parent organization for better care coordination and integration.

Enrollment in Medicare Medi-Cal Plans is Voluntary

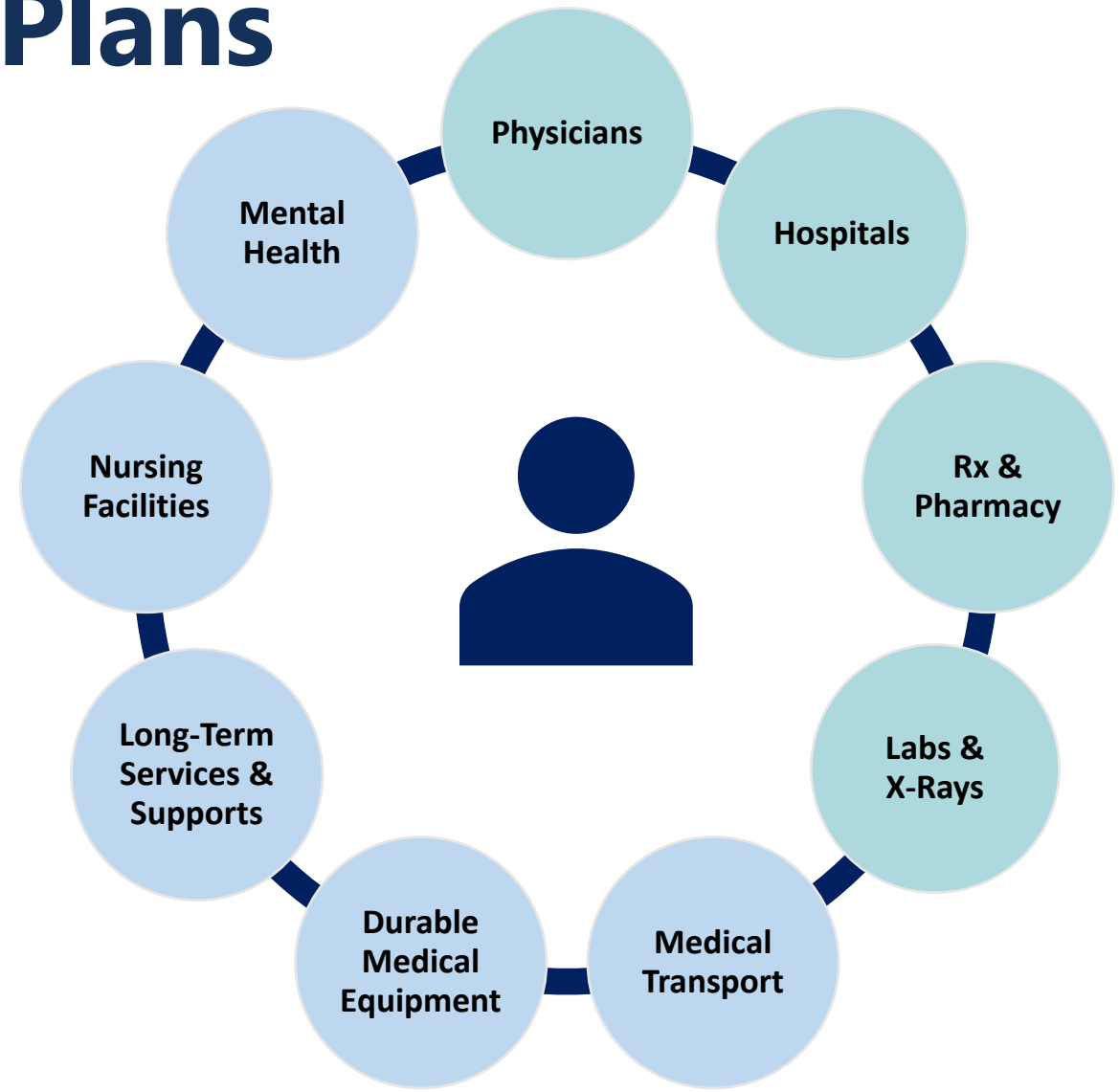
- In CCI counties, members in Cal MediConnect plans will transition into Medi-Medi Plans on January 1, 2023.
- Dual eligible beneficiaries who are not Cal MediConnect members will also have the option to enroll in a Medi-Medi Plan in CCI counties.
- Enrollment in Medi-Medi Plans is voluntary, and beneficiaries retain the choice of any other Medicare options, such as:
  - Original Medicare
  - Medicare Advantage plans
  - Program of All-Inclusive Care for the Elderly (PACE).
  - There will not be any changes for beneficiaries currently enrolled in Original Medicare.
- In 2023, Medi-Medi plans are available in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties.

Services Provided Through Medicare Medi-Cal Plans

- Medi-Medi Plans provide the following services to beneficiaries:
  - All Medicare covered services, including medical providers, hospitals, prescription drugs, labs, and x-rays
  - All Medi-Cal covered services, including Long-Term Services and Supports, durable medical equipment, medical transportation, and Medicare cost-sharing
  - Additional supplemental benefits over and above original Medicare and Medi-Cal (e.g., acupuncture, meals following a hospital stay, and nutrition/wellness).
  - Coordination with carved-out benefits, such as In-Home Supportive Services (IHSS) and Medi-Cal Specialty Mental Health Services (SMHS) provided by the county
  - Similar care coordination and providers as Cal MediConnect plans
  - One care management team to coordinate care and help a beneficiary manage their services

Care Coordination in Medicare Medi-Cal Plans

- Medi-Medi Plans will help beneficiaries with all their health care needs and will coordinate benefits and care, including carved-out benefits, medical and home and community-based services, durable medical equipment, and prescriptions.



Questions?

Care Management, Transitional Care Services, and Duals Care Coordination

Community Supports

What are Community Supports?

Community Supports are services that Medi-Cal managed care plans (MCPs) are strongly encouraged but not required to provide as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

- Community Supports are designed as cost-effective alternatives to traditional medical services or settings and to address social drivers of health (factors in people's lives that influence their health)
- Different Medi-Cal MCPs offer different combinations of Community Supports
- Medi-Cal MCPs must follow the DHCS standard Community Supports service definitions in the policy guide, but they may make their own decisions about when it is cost effective and medically appropriate
- Community Supports are not restricted to ECM Populations of Focus and should be made available to all Members who meet the eligibility criteria for a specific Community Support

For more details, see Community Supports Policy Guide (December 2022).

What are Community Supports?

Pre-Approved DHCS Community Supports

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Meals/Medically-Tailored Meals or Medically-Supportive Foods
13. Sobering Centers
14. Asthma Remediation

For more details, see Community Supports Policy Guide (December 2022).

Community Supports for Members in Long-Term Care Populations of Focus

The entire menu of Community Supports may be applicable to Members in the Long-Term Care Population of Focus, but each Member will have different needs and functional limitations.

Community Supports that may benefit members in the Long-Term Care Populations of Focus include, but are not limited to:

- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Environmental Accessibility Adaptations (Home Modifications)
- Respite Services
- Personal Care and Homemaker Services

For more details, see Community Supports Policy Guide (December 2022).

How Do Members Access Community Supports?

- **Members who qualify may be contacted directly by their health plan and/or a Community Supports provider.** Medi-Cal health plans are responsible for regularly identifying Members who may benefit from Community Supports and who meet the criteria for the program. Once a Member is identified, the health plan and/or their assigned Community Supports provider will contact them to discuss Community Supports.
- **A health and social services provider, including an ECM or Community Supports provider, may submit a referral for Members.** If a member has not yet been identified by the Medi-Cal health plan as eligible for Community Supports, but appears to meet the requirements, their provider can submit a referral to the Member's health plan. The health plan is required to have a referral process that is available for health and social service providers. You do not need to be a clinician to refer someone to Community Supports.
- **Members may self-refer or ask for information to see if they qualify.** A Member or the Member's family can contact their Medi-Cal health plan to see if they qualify for Community Supports. Members can contact their health plan by calling the number on the back of their insurance card.

Transportation Benefits

Medi-Cal: Transportation Benefits

- Providers should work closely with Medi-Cal MCPs to understand the transportation request process. Prior authorizations may be required for NEMT. Medi-Cal MCPs contract with different transportation vendors and have policies and procedures in place to ensure timely access and to offer transportation options that can meet a Member's needs.
- Additional information may be found on the DHCS Transportation Services FAQ

Non-Emergency Medical Transportation (NEMT) is transportation by ambulance, wheelchair van, or litter van for beneficiaries who cannot use public or private transportation.

- Available when medical or physical condition does not allow travel
- Services must be prescribed by a health care provider.

Non-Medical Transportation (NMT) is private or public transportation to and from covered Medi-Cal services for eligible beneficiaries.

- Available to all beneficiaries with full-scope Medi-Cal and to pregnant women
- Beneficiaries will need to attest to the provider they have an unmet transportation need and all available resources have been exhausted.

SNF Services: Inclusive and Exclusive

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: 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 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).

Per Diem Rate: Exclusive Therapy Services

- Medi-Cal MCPs and SNFs can negotiate payment for other therapy services outside of the directed payment rate.
- 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.
- 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?

Community Supports, Transportation Benefits, SNF Per Diem Inclusive and Exclusive Services

SNF Carve-In Webinars

Topic	Audience	Date and Time
SNF Carve-In Policy Updates	SNFs and Medi-Cal MCPs	February 24, 2023 2pm – 3pm
Medi-Cal Managed Care and Skilled Nursing Facility Residents	SNFs	January 30, 2023 2pm – 3pm
LTC Billing and Payment Rules	SNFs and Medi-Cal MCPs	December 2, 2022, 1pm – 2pm
Promising Practices for Contracting	SNFs and Medi-Cal MCPs	November 4, 2022, 1pm – 2pm
CalAIM LTC Statewide Carve-In 101 for SNFs	SNFs	October 7, 2022, 1pm – 2pm
CalAIM LTC SNF Carve-In 101 for MCPs	Medi-Cal MCPs	September 21, 2022, 10am –11am

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

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: Additional Resources - Inclusive and Exclusive Services

Occupational Therapy: Inclusive and Exclusive Services Chart

- This table illustrates the relationship between therapy services. This is not intended to be an all-inclusive list for when additional therapy services (beyond what is covered in the per diem), but provides some examples for specific therapy service types. Additional details on the inclusive and exclusive services chart can be found at TAR Criteria for NF Authorization (Valdivia v. Coye).

Occupational Therapy Services Table	
Inclusive Service	**Exclusive Service**
The nursing staff supports and encourages the Medi-Cal beneficiary at group activities program. The nursing staff encourages the Medi-Cal beneficiary at homemaking tasks and dressing skills.	Ongoing occupational therapist involvement would be necessary to conduct periodic assessments of the patient and evaluation of the patient specific treatment plan. A patient's plan of care calls for an occupational therapist to evaluate the patient's compensatory techniques and safety with regard to lower extremity dressing, hygiene, toileting and bathing.

Physical Therapy: Inclusive and Exclusive Services Chart

- This table illustrates the relationship between therapy services. This is not intended to be an all-inclusive list for when additional therapy services (beyond what is covered in the per diem), but provides some examples for specific therapy service types. Additional details on the inclusive and exclusive services chart can be found at TAR Criteria for NF Authorization (Valdivia v. Coye).

Physical Therapy Services Table	
Inclusive Service	**Exclusive Service**
The Medi-Cal beneficiaries plan of care calls for the application of foot, hand and arm splints to prevent contractures and allows range of motion exercises. The nursing staff applies the splints consistently and appropriately. The nursing staff encourages the Medi beneficiary self--Cal feeding at meals and his/her participation in NF activity programs	A physical therapist trains NF staff on a Cal recipient plan of care that states the recipient (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: Inclusive and Exclusive Services Chart

- This table illustrates the relationship between therapy services. This is not intended to be an all-inclusive list for when additional therapy services (beyond what is covered in the per diem), but provides some examples for specific therapy service types. Additional details on the inclusive and exclusive services chart can be found at TAR Criteria for NF Authorization (Valdivia v. Coye).

Speech Therapy Services Table	
Inclusive Service	**Exclusive Service**
Repetitive exercises, commonly a part of status post cerebral vascular accident plan of care, are rendered to improve gait or maintain strength and endurance.	The speech therapist's plan of care calls for speech therapy for a poststroke patient who is dysphasic.

Appendix B: Additional Resources - Enhanced Care Management and Community Supports

DHCS Resources & Materials

- Learn more about ECM & Community Supports:
  - ECM Policy Guide and Community Supports Policy Guide
  - FAQs
  - Fact Sheets: ECM & Community Supports
  - ECM Implementation Timeline & Updated Populations of Focus
    Community Supports MOC Template
  - ECM MOC Template Addendum II
- Review ECM & Community Supports guidance documents:
  - Billing & Invoicing Guide
  - Coding Options
  - Community Supports Pricing Guide (Non-Binding)
  - Data Guidance for Member-Level Information Sharing
  - Contract Template Provisions
  - Standard Provider Terms & Conditions

ECM Launch and Expansion Timeline

Counties in pink began implementing ECM in July 2022, making ECM statewide

ECM Populations of Focus (POFs)	Go-Live Timing
• Individuals and Families Experiencing Homelessness • Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization • Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs • Individuals Transitioning from Incarceration (some WPC counties) ○ Individuals with Intellectual or Developmental Disabilities (I/DD) ○ Pregnant/Postpartum Adults	January 2022 *(Whole Person Care Pilots (WPC) and Health Home Program (HHP) counties)* July 2022 *(all other counties)*
• Adults Living in the Community and At Risk for Institutionalization and Eligible for Long Term Care (LTC) Institutionalization • Adults who are Nursing Facility Residents Transitioning to the Community	**January 2023**
• Children / Youth Populations of Focus	July 2023
• Birth Equity Population of Focus *(Members of this POF who are subject to racial and ethnic disparities)*	January 2024
• Individuals Transitioning from Incarceration	2024 (Date TBD)

ECM: Adults Living in the Community Who Are At Risk for LTC Institutionalization

Summarized Operational Guidance

Identification

- **Referrals** will be the predominant pathway Medi-Cal MCPs use to identify eligible Members
- Medi-Cal MCPs may also leverage existing **Member data**, data sharing with contracted Providers, 1915 (c) HCBS waiver program wait lists, previous SNF Level of Care determinations to identify members

Assessment and Care Plan

- **Assessment:** For Members who may have LTSS needs, Medi-Cal MCPs must continue to include DHCS' standardized Long-Term Services and Supports (LTSS) referral questions[1] as part of the assessment
- **Care Plans:** If the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, should reflect Member preferences, and should incorporate LTSS and all wraparound services and supports that will ensure the Member is setup to live continuously in the community

Provider Contracting

- Medi-Cal MCPs are required to contract with **providers who have experience** serving Members who meet this POF, which may include CBAS Centers, Area Agencies on Aging, Home Health Agencies, and Centers for Independent Living

For more details, see ECM Policy Guide (May 2022).

1. As established in APL 17-013: Link
2. As established in 42 CFR § 438.208: Link and 42 CFR § 441.301: Link

ECM: Adults Living in the Community Who Are At Risk for LTC Institutionalization

Interactions with Other Programs

Community-Based Adult Services (CBAS)	• Members in a CBAS program are eligible to receive ECM if they meet POF criteria
In-Home Support Services (IHSS)	• Members receiving IHSS are eligible to receive ECM if they meet POF criteria
1915(c) Waiver Programs	• Members can be enrolled in ECM *or* in a 1915(c) waiver program, but not both at the same time • If space is available in a 1915(c) waiver program, members may choose between ECM and the waiver program

For more details, see ECM Policy Guide (May 2022).

ECM: Nursing Facility Residents Transitioning to the Community

Summarized Operational Guidance

Identification

- To identify eligible Members, Medi-Cal MCPs can rely on **referrals, analysis of their own data, or direct data feeds/established relationships with SNFs or other Providers**.

Assessment and Care Plan

- **Assessment:** Medi-Cal MCPs must assess Members against criteria to determine who could be **successful to reside continuously in the community.**
  - *DHCS encourages Medi-Cal MCPs to use the California Community Transitions (CCT) assessment tool for this Population of Focus.*
- **Care Plan:** The ECM Care Manager is responsible for identifying all resources to address all needs of the Member, including coordinating with local housing agencies/identifying the least restrictive community housing option, ongoing medical care that may be needed, and other needed community-based services.

Provider Contracting

- Medi-Cal MCPs are **strongly encouraged** to contract with **CCT Lead Organizations.** These providers have existing relationships with community-based organizations, can coordinate community wrap around supports effectively, and have extensive knowledge of existing local community resources (e.g., housing wait lists).

For more details, see ECM Policy Guide (May 2022).

ECM: Nursing Facility Residents Transitioning to the Community

Interactions with Other Programs

California Community Transitions (CCT) Money Follows the Person (MFTP)	• Members can be enrolled in ECM *or* in CCT MFTP, but not both at the same time

Community Supports

Nursing Facility Transition/Diversion to Assisted Living Facilities (ALF)

This Community Support facilitates nursing facility transition back into a home-like, community setting and/or prevents skilled nursing admissions for Members with an imminent need for nursing facility level of care.

- Providers of this Community Support are responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration
  - Includes 24-hour direct care staff on-site to address unpredictable needs and ensure safety
- Allowable expenses are those necessary to enable a person to establish a community facility residence
  - **Can** include identifying/securing housing options and on-site services needed, coordinating a move into an ALF, and ongoing expenses for Members receiving the service in an ALF (such as ongoing companion services, therapeutic social/recreational programming, medication oversight, and assistance with ADL/IADL)
  - **Cannot** include room and board or other living expenses
- The organizations that Medi-Cal MCPs contract with for this Community Support must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner
  - Providers include (but are not limited to) case management agencies, Home Health agencies, adult residential facility (ARF)/Residential Care Facilities for the Elderly (RCFE) operators

For more details, see Community Supports Policy Guide (April 2022), ECM & Community Supports FAQ (August 2022).

Community Supports

Nursing Facility Transition/Diversion to ALF- *Continued*

Eligibility Criteria

For **Nursing Facility Transition,** eligible individuals:

- Have resided 60+ days in a nursing facility;
- Are willing to live in an assisted living setting as an alternative to a Nursing Facility; and
- Are able to reside safely in an assisted living facility (ALF) with appropriate and cost-effective supports.

For **Nursing Facility Diversion**, eligible individuals:

- Are interested in remaining in the community;
- Are willing and able to reside safely in an ALF with appropriate and cost-effective supports; and
- Must be currently receiving medically necessary nursing facility level of care or meet the minimum criteria to receive nursing facility level of care services and in lieu of going into a facility, are choosing to remain in the community and continue to receive medically necessary nursing facility level of care services at an ALF.

For more details, see Community Supports Policy Guide (April 2022).

Community Supports

Community Transition Services/Nursing Facility Transition to a Home

This Community Support covers non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for their own living expenses.

- Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and are payable up to a total lifetime maximum amount of $7,500
  - **Can** include: assessing housing needs, assisting in housing search, coordinating funding for environmental modifications
  - **Cannot** include: monthly rent or mortgage expenses

- Providers must have experience and expertise with providing these unique services and may include (but are not limited to): case management agencies, Home Health agencies, CCT/Money Follows the Person providers.

Eligibility Criteria

Eligible individuals:

- Are currently receiving medically nursing facility level of care (LOC) services and, in lieu of remaining in the facility or medical respite setting, are choosing to transition home and continue to receive medically necessary nursing facility LOC;
- Have lived 60+ days in a nursing home and/or Medical Respite setting;
- Are interested in moving back to the community; and
- Are able to reside safely in the community with appropriate and cost-effective supports/services.

For more details, see Community Supports Policy Guide (April 2022).

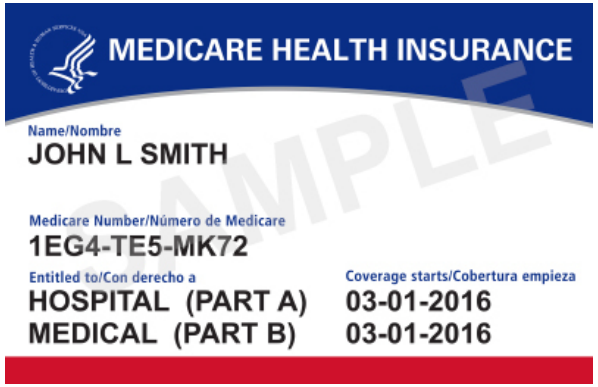
Appendix C: Additional Resources - Duals and Enhanced Care Management

Dual Eligible Beneficiaries

- Dual eligible beneficiaries are individuals eligible for both Medicare and Medi-Cal, often referred to as Medi-Medis.
- Nationally, dual-eligible beneficiaries were more likely than non-dual Medicare beneficiaries to report being in poor health (13% vs. 4%). They were also more likely to live in an institution (13% vs. 3%).
- In California, almost a quarter (22.4%) of Medicare beneficiaries were dually eligible for Medicare and Medi-Cal, or 1.4 million Californians. Of the 1.4 million dual eligible beneficiaries, 43% had Medicare Advantage (MA) and 57% had Original (Fee-For-Service) Medicare.
- The majority of beneficiaries residing in SNFs are dual eligible individuals.

Medicare, Medi-Cal, and the Need for Coordinated Care

- For most dual eligible beneficiaries, Medicare and Medi-Cal operate separately and with different funding streams.
- This fragmented system lacks incentives to provide these often high-need individuals with person-centered services.
- For dual eligible beneficiaries with high rates of chronic conditions and functional impairments, streamlined access to services across health and long-term services and supports (LTSS) systems is critical.



ECM Eligibility for Dual-Eligible Members
Overview for 2023 and Beyond

Figure 3: Overview of ECM Eligibility for Dual-Eligible Members in 2023 and Beyond

Medicaid & Medicare Delivery Model	ECM Eligible
Medi-Cal MCP + EAE D-SNPs	No
FIDE-SNPs	No
PACE Programs	No
Medi-Cal MCP + Medicare FFS	Yes
Medi-Cal MCP + Other MA	Yes
Medi-Cal MCP + non EAE D-SNP	Yes in 2023; No from 2024
Medi-Cal FFS + Medicare FFS or Plan *(not MCP enrolled)*	No
Any other excluded program (e.g., 1915(c), CCT)	No

Appendix D:
Grievances and Appeals

Grievances

- APL 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Template defines a **grievance** as:
- "(…) any expression of dissatisfaction about any matter other than an adverse benefit determination (defined below). Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the member's right to dispute an extension of time proposed by the Medi-Cal MCP to make an authorization decision."

Note: While state regulations do not specifically distinguish "grievances" from "appeals", federal regulations define "grievance and appeal system" to mean the processes the MCP implements to handle grievances and appeals, with the terms "grievance" and "appeal" each separately defined. Due to distinct processes delineated for the handling of each, health plans must adopt the federal definition but also incorporate applicable sections of the existing state definition do not pose conflicts.

Health Plan Grievance

- **Standard Grievance Process**
- *Through the health plan*
- Plan must resolve within 30-calendar days

- **Expedited Grievance Process**
- *Through the health plan*
- Plan must resolve within 72 hours

Note: Member can request a State Fair Hearing at any time during the appeals process.

Appeals

- APL 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Template defines an **appeal** as:
- "(…) federally defined as a review by the Medi-Cal MCP of an adverse benefit determination. While state regulations do not explicitly define the term "appeal," they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal because they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit. The Medi-Cal MCP must treat these grievances as appeals under federal regulations. Medi-Cal MCPs must use the federal definition of "appeal" and comply with all existing state regulations as they pertain to the handling of appeals."

Note: While state regulations do not specifically distinguish "grievances" from "appeals", federal regulations define "grievance and appeal system" to mean the processes the MCP implements to handle grievances and appeals, with the terms "grievance" and "appeal" each separately defined. Due to distinct processes delineated for the handling of each, health plans must adopt the federal definition but also incorporate applicable sections of the existing state definition do not pose conflicts.

Level 1: Health Plan Appeal

Standard Appeal Process

- *Through the health plan*
- Plan must resolve within 30-calendar days
- Benefits continue (Aid Paid Pending) if filed 10-days of NOA.

Expedited Appeal Process

- *Through the health plan*
- Plan must resolve within 72 hours
- Benefits continue (Aid Paid Pending) if filed 10-days of NOA

Note: Member can request a State Fair Hearing after completing the health plan's internal appeal process or in cases of Deemed Exhaustion at any time during the appeals process.

Level 2: Independent Medical Review

- *Through DMHC* (After filing Plan Grievance/Appeal)
- The member may ask for an Independent Medical Review (IMR) if the NOA indicates that the member's treatment is 'not medically necessary" or "experimental" or "investigational".
- The member may ask for an IMR after 30 days from the date the grievance/appeal is filed or as soon as it's denied, whichever comes sooner.

Note: Member can request a State Fair Hearing after completing the health plan's internal appeal process or in cases of Deemed Exhaustion.

Level 3: State Fair Hearing Process

- *Through Department of Social Services*
- Must be filed within 120 days of receiving the Notice of Appeal Resolution
- Standard hearings must be resolved within 90 calendar days.
- Expedited hearings must be resolved within three working days.

Note: Member can request a State Fair Hearing after completing the health plan's internal appeal process or in cases of Deemed Exhaustion.

Grievances and Appeals Resources

- APL 21-011 Grievance and Appeal Requirements, Notice, and "Your Rights" Template
- DHCS Discrimination Grievance Policies and Procedures Website

Appendix E: 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.