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

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SPEAKERS

Kristin Mendoza-Nguyen
Bambi Cisneros
Stephanie Conde
Stephanie Mahler
April Watson

Kristin Mendoza-Nguyen:

Good afternoon, everybody, and happy Friday. My name is Kristin Mendoza-Nguyen with Aurrera Health Group. Welcome to today's webinar, The CalAIM Long-Term Care Statewide Carve-In 101 For Skilled Nursing Facilities. We are delighted that all of you were able to join us today for the kickoff of this webinar series. We have some great presenters with us today. We have Bambi Cisneros, Assistant Deputy Director for the Healthcare Delivery System at DHCS; Stephanie Mahler, Clinical Network Liaison, and April Watson, the Interim Provider Services Director at Health Plan San Mateo. The materials at the end of the webinar will be available on the CalAIM website.

Kristin Mendoza-Nguyen:

And just a few things to note before we start. Just some management items. This webinar is being recorded and participants are in listen only mode but will be unmuted during the Q and A discussion. So, please do use that raise the hand feature and the team will be able to unmute you during that point. And we highly encourage you to submit questions via the Q and A feature. The chat is disabled for attendees, so please do use that Q and A feature. It allows us to appropriately track the questions coming in today. And with that, I will turn it over to Bambi.

Bambi Cisneros:

Great. Thank you Kristin. Good afternoon everyone. Thank you for joining us this afternoon on a Friday. Happy Friday. So, for this afternoon, what we wanted to walk through with you, was to provide some background on the Long-Term Care Carve-In Transition, as it is one of the CalAIM initiatives, and some overview there. And then we will review this Skilled Nursing Facility Carve-In policy and what those impacts are to the managed care operations. And we'll have some time at the end of each of these segments to do some Q and A. And then we will also review member communications and readiness information as well as having Health Plan of San Mateo present on how long-term care providers prepare for the transition. And then, finally we will have another Q and A, and close with next steps. Okay. So, we will go through an overview of the Long-Term Care Carve-In in the context of CalAIM and we'll start there. So, you can go to the next slide please.

Bambi Cisneros:

I think most of you are pretty familiar with CalAIM, which is a multi-year initiative that the Department is undertaking, really aimed at improving the quality of life and health outcomes of Medi-Cal members. And the Department is doing this by implementing some pretty broad delivery system program and payment reform across the medical program. And one of those CalAIM initiatives is Benefit Standardization. And so this is where the Long-Term Care Carve-In fits in here and the goal of benefit standardization is really so that we're standardizing and aligning policies across the state, regardless of plan model type. And so the idea is that no matter which county the member lives in, the experience should be the same, and so that's really our principal goal. CalAIM includes an effort to carve in long-term care to Medi-Cal managed care statewide and it's a part of our overall shift to going towards Managed Long-Term Services and Supports, or

MLTSS, beginning in 2027. And long-term care services are included under the umbrella of that MLTSS. And again, the whole goal is really just to make that coverage of institutional long-term care consistent across all counties for all of our Medi-Cal members.

Bambi Cisneros:

And so, the changes are being implemented in phases, depending on the long-term care facility or provider type. And so starting on January 1, 2023, Medi-Cal managed care plans in all counties will be required to cover the long-term care benefit for skilled nursing facilities which includes a distinct part, SNF, or a unit within a hospital. And it also means that all Medi-Cal beneficiaries residing in a long-term care facility are mandatory to enroll in the managed care plan for their Medi-Cal covered services. And so, we will be handling the transition of the ICF/DD benefit at a later time. Starting on July 1st, 2023, we will be carving in the Subacute Facility and Pediatric Subacute Facility, as well as the Intermediate Care Facility types listed here on this slide. And so, the focus of today will really be on the January 1, 2023 carve-in, which is specific to Skilled Nursing Facilities. You can go to the next slide please.

Bambi Cisneros:

Okay, so current state today is that in COHS and CCI counties long-term care services are carved in. And what this means is that plans that are operating in those counties are responsible for all medically necessary long-term care services, regardless of the length of stay in the facility. And so, if a member requires long term stays in a nursing facility, they continue to stay enrolled in that plan, to continue to receive those services, and they do not transition to Fee-for-Service. So, they get all their services within the managed care plan. And then, the managed care plan, or the Cal MediConnect plan, if it's a CCI county, is responsible for coordinating the member's care with the long-term care facilities, as well as with other services. And so, that's today's current state. And we can go on to the next slide. Here on the slide is a list of the managed care plans that are our COHS plans and the counties, as well. And so, these are the COHS and CCI plans that already cover long-term care as a managed care benefit today. And so, for these counties, the Long-Term Care Services Carve-In doesn't impact them January 1st, because they already provide the benefits and services today. So, just wanted to give you a listing of these COHS and CCI counties, because we do make reference to it throughout the presentation. And we can go to the next slide. Thank you very much.

Bambi Cisneros:

Okay, so now we'll talk about the non-COHS and non-CCI counties in today's environment. So, in other counties that are plan model types that are not COHS or not CCI, plans are responsible for long-term care services from the time of admission into the facility and the following month. And so, what that means is that if a member requires long-term care services in a facility for longer than two months, then the plans are required to disenroll the member and coordinate their transition to Fee-for-Service for the member to continue to receive those long-term care services. And in the

meantime, plans are responsible for providing all the medically necessary covered services to the beneficiary, but just not the long-term stay for the non-COHS, non-CCI counties. And then we have in the slide here just a list of the non-COHS and non-CCI counties and so this really shows you where the SNF Carve-In taking place on January 1, 2023, will have impact in the way that long-term care services are provided. So, we're just providing that here for you. And then, the next slide is just a visual depiction of a map showing those counties.

Bambi Cisneros:

We're also indicating here that we are estimating about 28,000 individuals that are residing in SNFs will be carved into Medi-Cal managed care and most of those members are duals. So, they have Medicare and Medi-Cal coverage. So, the counties on this map that are in the shades of purple represent the CCI and COHS counties that will have long-term care carved into Medi-Cal managed care today. And then the blue counties identify the remaining counties in which long-term care will be newly carved in January 1, 2023. And so, you have that there. Okay, I think you can go to the next slide please. Okay. So, for statewide managed care, now that we've reviewed how some of the long-term care services are covered today, we'll take some time to go over what will change after the January 1, 2023 Carve-In. And so, as we talked about in earlier slides, we are taking a phased approach to implement the changes based on the facility type. And so, starting January 1, 2023, the Skilled Nursing Facility benefit will be available statewide, across all plan model types already offered in COHS and CCI today. And so, the expansion is really just to those non-COHS, non-CCI counties. And then, on July 1st, the Department will carve-in the Long-Term Care benefit for the subacute as well as the intermediate care facilities as well.

Bambi Cisneros:

So, I think it would be good to orient, or reorient, ourselves to the carve-in goals because it's always helpful to be reminded as to why we're making these changes because changes, they can be hard. And so, just really a reminder that this fits under the CalAIM Benefit Standardization Initiative as part of CalAIM. And those goals are really just to standardize and align those benefits across the state. Again, because we want the member experience to be the same no matter where they live or transition to. And so the goals of the SNF Carve-In specifically, is: to standardize those SNF services coverage under managed care statewide, advance to a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility, as well as increase access to care coordination and care management and a broader range of services for Medi-Cal beneficiaries which the plans have within their scope of services under their plan contract. And so, we really see this transition being helpful to advance members to just having that seamless experience and also our ability to oversee the managed care plans in a standardized aligned way as well.

Bambi Cisneros:

And so, we talked a little bit about this already, about just what is changing between non-COHS, non-CCI, to those plans that are already covering these services today. And so, just to emphasize that after the January 1, 2023 Carve-In date, what that means is that beneficiaries who enter a skilled nursing facility and would otherwise have been disenrolled from the managed care plan, will not be disenrolled to fee-for-service, but instead will remain enrolled in the managed care plan to continue receiving those services. And then, beneficiaries residing in a skilled nursing facility on January 1, 2023, will be enrolled in a managed care plan effective January 1, 2023. And this includes most Medi-Cal beneficiaries. And then, the member's effective date is really dependent on whether they make an active choice to enroll in a plan. So, if a member chooses a plan prior to the MEDS [Medi-Cal Eligibility Data System] renewal that happens in December, 2022, the effective date of plan enrollment will be January 1, 2023. But, wanted to highlight that if a member does not choose a managed care plan, they fall under our typical default assignment or default enrollment path. And so, for members who go down that default path, because they don't choose a plan in January, 2023, the planned effective enrollment date will be February 1st, 2023. So, wanted to just highlight those pieces.

Bambi Cisneros:

Okay, so, next we are going to talk about the policy requirements and what we are doing to implement these requirements with our managed care plans as we go through this transition. And so, that's what the next few slides will cover. So, first we will talk about continuity of care and when it comes to this carve-in, there are really three aspects of continuity of care that is pertinent to beneficiaries residing in a skilled nursing facility. And the first is really related to the SNF services itself and it applies to members who are already in a skilled nursing facility on January 1, 2023, and were previously in fee-for-service. So, when beneficiaries enroll in a managed care plan, the managed care plan is required to provide continuity of care under certain conditions. And so, those conditions are: the facility is licensed by the California Department of Public Health, the facility meets the plan's quality standards, and that the facility and the managed care plan can agree to work together. And so, if those conditions can be met, then members must be allowed to stay in their current skilled nursing facility residence. And so, that's an important provision there.

Bambi Cisneros:

This continuity of care protection applies to all skilled nursing facility residents transitioning on January 1, 2023. And so, after 12 months, members may request an additional 12 months of continuity of care, but generally our continuity care policy is 12 months in duration. And one thing that's really important for this population is that this continuity of care protection is automatic, which means that the beneficiary does not have to request to stay in their facility. And so, if these conditions are met, the ones that we just walked through; and it's highlighted on the second bullet here on this slide; then the member should be staying in their facility. And if the member is unable to access continuity of care as these points mentioned, then the managed care plan must provide

the member with a written notice of action, or a notice of adverse benefit determination, and also be responsible to find the member alternative placement.

Bambi Cisneros:

Okay. So, next we can go into continuity of care as it applies to providers. So, an important difference between continuity of care for SNF services and continuity of care for providers, is that to stay with their providers, members must contact their managed care plan to request to keep seeing their provider. And it could be the member, or their authorized representative, or provider, to make the request, but they do have to make the request for continuity of care to the provider. And similar to the other continuity of care policy for services, the period of continuity of care is 12 months. So, what this means is that the managed care plan, as long as these conditions are met, again, like the member, authorized representative, or provider makes a request and then there's a preexisting relationship that the member has with the provider. And we're defining that preexisting relationship to be: having seen that primary care provider or specialist at least once during the previous 12 months, and that there are no quality issues that the plan has with the provider, and that the provider and the managed care plan can agree on payment and rates. Then the managed care plan must honor that continuity of care request for the Medi-Cal member to see their provider out-of-network.

Bambi Cisneros:

And so, this includes out-of-network specialty mental health service providers in instances where a member's mental health condition has stabilized to the point that the member no longer qualifies to receive specialty mental health services, which is received from the county mental health plan, and instead, becomes eligible to receive non-specialty mental health services. Which the managed care plan does provide under their managed care contract. And so, we do have all of these continuity of care policies outlined in All Plan Letter 18-008, which we did link here, and that'll take you directly to the APL. And so, you'll see there that there are other provisions for continuity of care for providers, but it excludes providers of DME, transportation, ancillary service as well as carved out services. And so, what this means is that the member has rights to continue having those services, but not necessarily the same provider who was providing those services.

Bambi Cisneros:

And so, one of the things we wanted to note here is that the majority of individuals affected by the SNF Carve-In are dual eligible members. So they have Medi-Cal and Medicare. And so for duals, for dual eligible members, Medicare providers, including primary and specialty care and hospitals, do not change and do not have to be in the plans network. Okay. So we can go onto the next slide, please. Okay. And then, the third aspect of continuity of care is applicable to other Medi-Cal services. And so, what we have here on the slide is talking about prescription drugs. So, for prescription drugs, continuity care allows members to maintain their current drug therapy, which includes non-formulary drugs, until the member is evaluated, or reevaluated, by the plan's

network provider. I think in our APL, we do outline more details on the Medi-Cal Rx and pharmacy policies, which then link to the requirements in welfare institutions code. So we'll see that in the APL which is listed on these slides as well. Okay, we can move to the next slide, please.

Bambi Cisneros:

And then for other services, continuity of care provides continued access to other services which could require a switch to an in-network provider, as I mentioned. And so, these include transportation services which are non-emergency medical transportation and non-medical transportation, and some select ancillary and medical supplies. So, we are working on additional policy in 2023 that may enable members to keep their provider for DME and medical supplies for the first 90 days and also some other ancillary providers such as physical therapy, occupational therapy, and speech therapy for up to 12 months. So we're continuing to work on that. And so, one of the things that would be important to highlight here is that similar to the other continuity of care provisions, is that if the plan and the provider is unable to work together, then the plan will need to work on finding that care for beneficiaries within their own network to continue those services. Okay, go on to the next slide, please.

Bambi Cisneros:

So, that was the continuity of care policy, and again, a lot more detail that was in the All Plan Letter that was posted last week, two weeks ago. And, so now, what can skilled nursing facilities do to prepare? Where we are now. And so, I think what we would recommend is of course the plans would be working with their skilled nursing facilities to try and enter into those contracts. They are to work together to prepare and engage ahead of the transition and really talk about these continuity of care policies and procedures to see some very specific member situations. And again, the overall goal is to ensure that member access to their essential services is retained during this transition. So it's really important that they have that continued and open dialogue. And as I mentioned earlier, that we are working on is a forthcoming continuity of care policy that would have further detail and information on where we are headed with DME and medical supplies from out-of-network providers. And so I think we'll continue to just work through that and work through the stakeholder process. So, there'll be more to come on this piece.

Bambi Cisneros:

And then, as well, the Department will continue to provide member level data to managed care plans monthly. So, we do this today and so we'll continue to do that and provide information to the managed care plans, so they're aware of the kind of services that the members are receiving and they can use this information to work on those continuity of care requests. Okay, we can transition to Leaves of Absence and Bed Holds. So, leaves of absences and bed holds. These are other member protections for members that are residing in a skilled nursing facility and these really just are periods of time when a facility resident may leave the facility while still having the ability to return

and the facility will continue to receive some payment. And so, these requirements are really dictated in statutes, as well as described in the APL, as well as the provider manual. And so, plans may require prior authorization for bed holds and leaves of absences. And we really see these as the key to maintaining the level of care needed for members as their needs may change and their care settings may need to change temporarily.

Bambi Cisneros:

And so one of the things that we're going to be looking at when working with the plans and overall compliance is their compliance to these Leave of Absence and Bed Hold policy to really ensure that members maintain these obligations and allowing for continuity care for members. And we can go to the next slide, which gives a little bit more detail. Again, linked here is the provider manual on leaves of absence, which is pretty defined in regulations, statute, and the provider manual. And we just have here listed that there are allowable leave of the absence durations per calendar year. So, 73 days per calendar year for developmentally disabled patients, 30 days for patients in certified treatment programs – tied to behavioral health – and then 18 days for all other patients, with up to 12 days of additional days of leave per year. Again, leave of absence payments are not made if a member is discharged during the leave of absence or discharged within 24 hours after returning to the skilled nursing facility and these requirements are outlined and specified in Title 22 and the provider manual linked on this page.

Bambi Cisneros:

Okay, next slide please. Again, in terms of Leave of Absence and Bed Holds, managed care plans are required to ensure bed holds are utilized if a member takes a leave of absence and members must also be allowed to return to the skilled nursing facility that they were previously in. And then, the managed care plan is responsible for the coordination of that transition. And so, we do require managed care plans to address any denials of bed holds with the skilled nursing facility to ensure that members have appropriate access, as well as the plans being responsible for notifying members in writing of the right to a bed hold. And so those are some of the plan requirements that we will be looking to oversee as we work with the plans on this implementation.

Bambi Cisneros:

So, when it comes to leaves of absence and bed holds, how can facilities prepare? So, as we talked about, bed holds are a covered benefit under a member's Medi-Cal benefit. And so, skilled nursing facilities should become familiar with the appropriate contacts at the plan, just to make sure that these authorizations can be obtained when needed. And so, typically these are with the utilization management contacts at the managed care plan. And so, then the other piece as well is that there are timely and accurate authorization submissions coupled with an understanding of the timeframe for review of authorizations and that is really critical to ensuring that members have access to care. One other important piece that we wanted to flag for this group here as well is

that it really will be critical for the managed care plans and the skilled nursing facilities to work closely together to obtain a bed hold authorization in order to support the member. And again, I think there are additional details needed in terms of these requirements. That is all pretty specified in the Medi-Cal provider manual.

Bambi Cisneros:

Okay, we can move on to the next slide. So, for authorizations, we have Treatment Authorization Requests and Service Authorizations. And so for Treatment Authorization Requests, or TARs, managed care plans are required to maintain continuity of care for members in a skilled nursing facility and they need to recognize any treatment authorization requests for the member enrolled in the plan. And so, plans are responsible for all other approved TARs for services in a SNF exclusive of the long-term care per diem rate for a period of 90 days after enrollment in a plan and not before the plan is able to reassess the member and authorize and connect the member to medically necessary services. And when it comes to service authorizations, prior authorization requests for members transitioning from an acute care hospital must be expedited. And so we're looking at this under expedited timeframes. And so what that means is that for service authorization, they need to be processed within 72 hours, which includes weekends.

Bambi Cisneros:

So, for authorizations and when working with plans, facilities should be sure to understand that there are some plan-specific policies for authorizations and it would be also good to have an understanding of how to verify the member's plan eligibility, as well as how to provide clinical documentation that's required for those authorizations that the plans may be seeking from the facilities. Plans will be offering detailed trainings to providers so that the care team members understand the steps and the requirements for obtaining these various authorizations that's needed in order to provide care and services to the Medi-Cal members.

Bambi Cisneros:

And so, a few steps that we are recommending for the Skilled Nursing Facility care team to consider as part of their overall readiness for the Long-Term Care Carve-In include, of course, attending any plan-specific trainings on the authorizations, clarity on plan, form or process, for submitting a referral for authorizations, having an understanding of validating member eligibility, clinical documentation and evidence. I think just being prepared to provide that as needed. Understanding placement criteria for an appropriate level of care evaluation, providing detailed and clear documentation for the initial submissions of the managed care plan when they do request for this information, as well as just gaining clarity on the length of time that the different types of authorization approvals takes. And these are all dictated in contract and statute. And then finally, just having an understanding of the re-authorization process when an authorization termination date is approaching. So, I think these are all some pretty good practices for how facilities can start preparing for authorizations.

Bambi Cisneros:

I think we have a little bit more authorizations on the next slide here. So as I mentioned, and is also specified in the All Plan Letter, prior authorization requests for members who are transitioning from an acute care hospital is considered expedited, which means that responses are to be made within 72 hours including weekends. And so, it's going to be really critical for the facilities and managed care plans to work closely together to ensure that this timeline is met. And so, just here on the slide, we just lifted up the timeframes for authorizations that are specified in health and safety code as well as in the managed care plan contracts. So, plans have 5 working days for routine authorizations and when there are things that require expedited authorizations, it's required to be acted on within 72 hours as we had discussed.

Bambi Cisneros:

Okay. So, moving on to care management and care coordination. One of the benefits of having these services under the managed care plan is that managed care plans are required to provide care coordination as part of their contract. And so, various requirements that's tied to that. And so care coordination is really specific to the member needs, but generally it includes a comprehensive assessment of the member's condition. It means looking into what other available benefits and resources might be helpful for the member and then developing and implementing a care management plan. And that care management plan is usually worked on with a care team as well as the member. So, that should be member-centered and that care plan includes the performance goals, what they're trying to achieve, monitoring, and follow up. And so, the care team is all aware of what the member's needs are and are working together to meet those needs.

Bambi Cisneros:

And in addition, starting this year, plans are offering Enhanced Care Management and Community Supports, which do vary by plan, by county. And so we do expect plans to also assess members that would be good candidates to receive ECM and Community Supports if it's medically necessary. So, Skilled Nursing Facility Carve-In is really part of a larger Population Health Management strategy that the Department is undertaking. I think carving it into all of the plan models statewide is the first step. And so, with Population Health Management, that really just means having access to a comprehensive set of services based on the member needs and preferences as a population. And so Population Health Management will begin in January 2023 and managed care plans will continue rolling out new requirements on this phased approach as the Department continues to work with stakeholders on fleshing out what this Population Health Management program will entail.

Bambi Cisneros:

But what I would say is, as a part of that Population Health Management, managed care plans are required to make sure that there is a care manager that will assist members during their transition to and from a skilled nursing facility and also ensure that medically

necessary services are being provided timely and completely. And the ways that skilled nursing facilities can learn more about how to ensure that members' needs are being met is to really get connected to the managed care plan's care manager or their Long-Term Services and Supports, or LTSS, liaison. And we do also highly encourage skilled nursing facilities to work in partnership with managed care plans and determine if members can also benefit from other services such as Enhanced Care Management, or ECM, Community Supports, complex case management, or any other services that are available under the Medi-Cal managed care contract.

Bambi Cisneros:

Move on to the next. So, moving on into this segment, we'll talk a little bit about member communications and so this is really about how the Department is planning to conduct outreach to members who are part of this transition, and so we can move on to the next slide. Oh, thank you. So, we are sending targeted notices to explain both the transition to a managed care plan, the beneficiary's options, as well as continuity of care for long-term care residents. And so, the Department is putting together two notices which will be sent, and these notices will also be accompanied by a Notice of Additional Information and this is in an FAQ format. And so the Notice of Additional Information will be included in both the 60 and the 30 day notice and then just goes into a little bit more detail about what are the changes, about the long-term care changes. And then the 60 day and 30 day notices really just explains what's changing, information about managed care plans, it also provides contact information on contacting Health Care Options as well as providing information about continuity of care.

Bambi Cisneros:

The notices also would indicate the health plan that the member is assigned to. So if the member doesn't make an active choice to enroll in a plan, the Department has this process to do provider linkage to see if the member has any link to the managed care plan and we'll assign that member to the managed care plan. And then if they don't make a choice, then they'll go through that auto-assignment default path. And so slide 31 is a visual depiction of what we just went through with the notices. With the 30 day and 60 day notices going out November and December, as well as choice packets going out in December, leading up to the January 1, 2023 Carve-In. One of the things that we're also doing in addition to the member notices is having an outbound call campaign that Health Care Options is going to be doing for us and this is just making sure – and I'm sure not everyone may check their mail these days – and so just having that extra outreach to make sure that members are aware of the changes that are coming up and that we can answer their questions about the transition.

Bambi Cisneros:

Okay. So, I think that wraps up some of the policy requirements and implementation plan highlights as well as member communications. Kristin, I think I'll turn it over to you to see if there's questions or if we want to move to the next segment.

Kristin Mendoza-Nguyen:

Yeah, lots of questions. So, some of the questions that came up ... One of the first ones that came in is, "Will the managed care plans have standardized regulations for TARs and payments, or is it going to be up to the plan to make up their own rules like they do now?"

Bambi Cisneros:

Well, there's some standard requirements for authorizations such as the timeframes that we had mentioned in previous slides, but plans do have their own processes as well. And so, one of the things that we look for when we do our monitoring and also something that Audits and Investigations looks at when they do their annual medical audits is just adherence to contractual and statutory requirements tied to those authorizations. So, we just want to make sure that it's sound. So there's baseline, but there's also some flexibility is what I would say.

Kristin Mendoza-Nguyen:

Okay. And another question, "Is the expectation that the MCPs participate in all MDT or care plan meetings with the SNF?"

Bambi Cisneros:

Yes. So, it's the plan, but really it's the providers. So, we want it to be the members and their care team. The providers that really have an understanding of where the member is and what their goals are that would be documented in that care plan. And the managed care plan also has a responsibility for ensuring that those meetings take place and are aware. And of course, I think, ultimately are approving those services for whatever is medically necessary and included in that care plan.

Kristin Mendoza-Nguyen:

Okay, great. And I do see two hands. Debbie, unmute, to ask your question. Oh, we'll give her a minute. I think she's trying to unmute. So we'll go to Lourdes D, if you want to ask your question. Okay. I think folks ... You should be able to unmute yourselves. Okay, we'll troubleshoot, and we'll come back to those folks and we'll go to the written ones. So, there's lots of questions. I think there were a couple on special treatment programs. So, "Will SNF special treatment programs or STP services, accommodation codes 11 and 12, provided in a SNF and/or in a SNF designed as an IMD, be carved into services covered by MCPs effective July 1st of next year when the ICF/DDs are carved in? If not, is there a timeframe for STP services to be carved into MCPs?"

Bambi Cisneros:

Yeah, thank you for the question. Regrettably, I don't know those accommodations off the top of my head, but I think it sounds like those are behavioral health related and we did get that question offline and are working on addressing that in an FAQ, just pulling some data. And so, I think for that one, I believe those are the behavioral health related accommodation codes and so we will address that in the FAQs. I don’t know if we have

that answer today, but we are looking into it. We have received it, so just want to acknowledge that.

Kristin Mendoza-Nguyen:

Okay. All right. There's a number of questions on different, choosing their plans or enrollments. So let me go to those ones… "What is the cutoff date for members selecting their plans in December for the 1/1/2023 effective date?"

Stephanie Conde:

It cut off. Hi Bambi, it's Steph. Hi folks, this is Stephanie Conde from Management Operations Division. The cutoff date for plan selection or, what we call choice, is at the end of December for an effective date of January 1st. And then, Bambi walked through the default dates. So, the default dates are in January for an effective date of February 1st.

Kristin Mendoza-Nguyen:

Okay, great. Thank you. Stephanie. "Once enrolled in an MCP, can a member choose to disenroll and enroll in another MCP at any time?"

Stephanie Conde:

A plan choice is month to month. So yes, a member can decide to change a plan, but they are in that plan for the entire month and then their new plan selection is active the following month.

Kristin Mendoza-Nguyen:

Okay, great. I'm going to try unmuting folks. So either ... Let me try Susan. Let's see if you're able to-

Susan LaPadula:

Hi, good afternoon.

Kristin Mendoza-Nguyen:

Oh, hello. Go for it.

Susan LaPadula:

Hi.

Bambi Cisneros:

Hello.

Susan LaPadula:

Hi Bambi, how are you?

Bambi Cisneros:

I'm good, how are you? Happy Friday.

Susan LaPadula:

I'm well, thank you. Very good presentation as always. Thank you for this. My question has to do with hospice eligible enrollees. If you can walk me through the non-COHS, non-CCI, as well as the COHS and the CalAIM CCI counties. How will this be handled: hospice eligibility?

Bambi Cisneros:

Susan, can you say a little bit more about that? Is it enrollment-

Susan LaPadula:

Certainly-

Bambi Cisneros:

... care coordination or…

Susan LaPadula:

Yes, this would actually have to do with reimbursement. In our skilled nursing facilities and in the subacute care facilities, we care for hospice eligible enrollees at various levels of care, for example, general inpatient or routine. And we're paid a percentage of our reimbursement for caring for the hospice residents. And we also have the full care team of ours as well as the full care team from the hospice organization helping the member and the family through this very difficult process.

Bambi Cisneros:

Okay. Yeah. I don't know about that specific situation, especially as it's tied to reimbursement. I don't know if we have the right folks on either. We may have to take that one back, Susan, and get back to you.

Susan LaPadula:

Thank you so much. It may end up being an exception like we have for some of our other categories.

Bambi Cisneros:

Yeah.

Susan LaPadula:

Okay. Thank you so much, Bambi.

Bambi Cisneros:

Yeah, no, absolutely. I wonder if ... Kristen, are we having folks send questions into a particular inbox? Because I would like to capture that.

Kristin Mendoza-Nguyen:

Yeah, we'll put in the chat for everyone for everyone, the info@calduals... Yeah.

Bambi Cisneros:

Okay, perfect. Yeah, if you can send that question in, Susan, to that CalDuals inbox, that Kristin will send around, that would be helpful because I think we'd have to check with a few folks here internally.

Kristin Mendoza-Nguyen:

Okay, great. I know there's still a number of questions. We do have one more Q and A at the end. So, right now I will turn it over to our partners at Health Plan San Mateo. So, April, do you want to take it off?

April Watson:

Sure, thanks. Thumbs up if you can hear me okay. Great. Okay, thank you. Yeah, thanks everyone. Thanks for the opportunity to speak to this group. We can go to the next slide. Actually, I think it's just our contact information or our names and titles. I'm April Watson, the Interim Provider Services Director with Health Plan San Mateo. And we also have Stephanie Mahler, who's our Clinical Network Liaison. I think she's through the phone, so I don't think we'll be able to see her unfortunately. So, next slide. We were just invited to come and talk about lessons learned and best practices as a COHS county in the experience of transitioning this benefit. And so, a little bit of historical context first before we move on to actually do that sharing, which is that Health Plan of San Mateo, we assumed responsibility for the Medi-Cal Long-Term Care benefit actually back in 2010. So, we've been doing this for a bit of time now.

April Watson:

We had already been working with some of our local SNFs since about 2006 because we had a Dual Eligible Special Needs Plan, then responsible for the Medi-Cal, or – Medicare, excuse me, skilled nursing benefits. So we had even a bit of experience prior to that. And the context in our area, in San Mateo County, was that we had about 10% fewer beds over the course of about a decade available for Medi-Cal members for a number of different reasons. And so, we were seeking to increase capacity and also we wanted to look at how might we reduce perhaps some unnecessary long-term care placements. We introduced the Community Care Settings program to do that. And then, another piece that we did was we introduced a Long-Term Care Collaborative in 2018. So, that's just a little bit of information to paint the picture of what was happening with us and a couple steps that we took a number of years ago.

April Watson:

So, if you move to the next slide, really what this is, is a summary of what we feel like those promising practices – I won't call them best practices necessarily – but promising practices that we think have supported us being able to successfully manage this were. So, Stephanie is actually our clinical network liaison, and holds a role that is really about relationships and communication with SNF and long-term care facilities in our area. So, I'll let her speak in just a minute. We did enact some payment changes and as I mentioned, we had launched a nursing facility collaborative. I think those are some of the actions we took and a lot of it was around direct relationship building. And I think for skilled nursing facilities, those of you who are on the call and are skilled nursing facilities, I think there's opportunities for sure as you're embarking on this transition. And I think the headline of what I'm about to say is really around communication and establishing direct lines of communication.

April Watson:

And so, some examples there that might be helpful is really understanding who might be a point person, or maybe there's a few of them with the health plans that you're working with that the Medi-Cal managed care plans ... who within those organizations should you be communicating directly with? And these plans would have a real incentive to set up those direct lines of communication, hopefully. So, I think just identifying people, individuals that you can start working directly with if you don't already have those relationships. So, that would be a place to start. I know Stephanie can speak more about this, but in fact Stephanie does and has been in many cases, participating in some of those care conferences for members who are transitioning from acute care to long-term care. And that's been really key. So perhaps being open to and inviting that level of participation, being proactive in communication around your bed availability, and also who you work most closely with at the acute care facility, so the hospitals as well, is really important for the plans to know and to have transparency in.

April Watson:

I'd say another point would be for expected transitions that will be happening from acute to long-term care, sharing with your health plan partners what additional supports those patients may need that you may not be able to provide. Because oftentimes the plans have resources to provide some additional supports. And then, any obstacles. Really, whatever your biggest obstacles are that continue to come up time and time again with those transitions, because I think that can be a really difficult process, oftentimes as they transition from acute to long term care. So, what are the obstacles that get in your way of having those transitions be smooth? That would be something to communicate with your plan around and to problem solve together. So those are, like I said, the headline really around establishing direct relationships to build communication. And I'm going to stop there and let Stephanie chime in and add more color to what I've just said before we turn to questions.

Stephanie Mahler:

Hi. Thank you, April. Can you hear me okay? I am on my phone, calling. Okay.

April Watson:

Yeah, we can.

Stephanie Mahler:

Yeah. So, boy, I'm excited about your guys' new journey in 2023 in launching this long-term care benefit, skilled benefit. April said it all. I just wanted to add that, again, key item is establishing a good relationship with your SNF and LTC partners, especially in your county and even out of the county. It's super crucial to build that with the administrators, the social workers and so forth in the skilled nursing facilities. I have to say that when we had our Nursing Facility Collaborative in 2019, it really, really rocket launched the communication and relationship because our collaborative was mostly in-person and then also, as a health plan, I and some others on our team, would go out and do visits at the nursing facility. So it increased that communication.

Stephanie Mahler:

Now, with that said, during our collaborative, we did also listen to our skilled nursing facilities on how to create a better payment model for them to get a little bit more reimbursement based around Medi-Cal rates and so forth. And that was another key area. Another one is – and obviously we want access to care and we want continuity of care and we want appropriate level of care – and sometimes we do have members that are very high risk. I'll just give you an example what some of the challenges we have as bariatric, over 550 pounds, it's really hard to find placement and work. And that's just one example. But what I have found is through the communications and respect and trust that you build with them, is all of them are willing to work to help you place patients that are coming from a hospital or, say, a home, to a SNF. I find it that my role is to work and find a place and keep that working relationship between the hospital, the SNF, our case managers, our UM department, our case management department, and all work together obviously to make things work for that placement.

Stephanie Mahler:

And I'm being very general, so I want to leave time for questions if you have it. But basically, I think Health Plan of San Mateo has come a long way. I've been there for a little over six years and I'm happy to say that I think we rock out there when it comes to the LTC and SNF benefit, transitions, payments, and relationships. Am I missing anything April?

April Watson:

Nope, thanks.

Stephanie Mahler:

Great.

Kristin Mendoza-Nguyen:

Okay. Any questions really briefly for Stephanie or April? I see some hands. I think these were ones from earlier, but any questions for April or Steph? Then we can pivot to any last ... I see a question from Sarah. I'm going to allow you to talk. Go ahead and unmute yourself.

Sarah Gonzaga:

Hi, I'm just wondering ... I'm not sure if they got to touch on this, but if they could speak to the point on payment changes including quality incentives?

April Watson:

Sorry, Sarah, can you repeat the question? I couldn't hear you very well.

Sarah Gonzaga:

If you could expand on the bullet point on the payment changes and quality incentives that are upcoming.

April Watson:

Sure. Yeah, I can, actually. I know we're running a little tight on time, but I can put a link ... Ooh, I don't know if I can share a link, but maybe subsequently we can share a link to our website where we have all the guidelines for our quality incentive program for long-term care. That was a payment model that was developed through our long-term care nursing facility collaborative that we launched back in 2018. Those guidelines will give you all the gory details, so I'm happy to share that link to be distributed after. Will that work, Kristin?

Kristin Mendoza-Nguyen:

Yeah, definitely. Thank you April.

April Watson:

Yeah.

Kristin Mendoza-Nguyen:

We'll make sure that you guys get that. Sure. All right. And then a question from Lourdes. If you want to unmute yourself. Okay. Debbie, do you want to unmute yourself? All right, let me see. Any other questions for April or Stephanie? I think we'll do one question from the chat. There's no others. So, there's a number of questions in the chat. I think a lot of them are very specific to certain counties, so we'll take those back. But I think one question that we could pose; and this might be, Bambi, for you. "What date can providers expect to see the managed care choice for their current LTC population in the state system for eligibility?"

Bambi Cisneros:

I think Steph may have addressed that already, but Steph, can I turn that to you?

Stephanie Conde:

Yeah, so, the choice is as soon as January 1st, and that will be reflected in AEVS [Automated Eligibility Verification System] on January 1st.

Kristin Mendoza-Nguyen:

Okay, great. I know we're running very short on time, so we will take these questions back. I know there are lots of questions on bed holds and some on TARs so we'll make sure to integrate those into the FAQs. But with that, I'm going to turn it over back, Bambi, to you to close this out for today. Oh, did we lose Bambi?

Bambi Cisneros:

Oh, sorry. No, I'm still here. I'm double muted and can't find buttons. Yeah, so I think we just really wanted to thank you all for your time and participation. We are going to be doing more webinars and outreach and working on FAQs and so I think we're going to grab all of the questions that you sent in the chat and really either outreach to you to provide you a response or if it's something that we may want to address in FAQs as well. So, I think we'll keep the dialogue going. We want to make this transition successful. So, please do let us know if you have any questions or concerns. Otherwise, more to come on this. Thank you so much.