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

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

DATE: Monday, January 30, 2023, 2:00 PM to 3:00 PM

NUMBER OF SPEAKERS: 5

FILE DURATION: 56 minutes

SPEAKERS

Kristin Mendoza-Nguyen
Bambi Cisneros
Dr. Laura Miller
Shel Wong
Beau Bouchard

Kristin Mendoza-Nguyen:

Good afternoon, everybody. I'm going to give one more minute to let everyone in from the waiting room. Happy Monday and good afternoon. Welcome to today's webinar. Today, we will be talking about how Medi-Cal Managed Care supports SNF residents. We're delighted that all of you were able to join today for the fourth webinar in this webinar series. We have a really large lineup of presenters today that I just wanted to quickly introduce.

Kristin Mendoza-Nguyen:

So, today, we have Bambi Cisneros, Assistant Deputy Director of the Healthcare Delivery Systems Division at DHCS; Dr. Laura Miller, Medical Consultant, Quality and Population Health Management Division; Shel Wong, Acting Section Chief over the Community Supports and the Optional Programs section of the Managed Care Quality and Monitoring Division at DHCS; and Beau Bouchard, Assistant Division Chief at the Capitated Rates Development Division at DHCS. The PowerPoint slides and materials will be available on the website and you'll find those in the link in the chat and then all previous materials from other webinars are also currently on the website. Next slide, please.

Kristin Mendoza-Nguyen:

We would ask that you take a minute now to add your organization's name to your Zoom name so that it appears as your name - organization. This helps track any questions that we need to follow up on. So, if you want to click on the participant's icon at the bottom of the window, hover over your name, and then you can right click and select rename and enter your name and add your organization as you would like it to appear. Next slide. Just a few things to note before we begin. This webinar is being recorded. You all are in a listen only mode and there will be a couple options for Q&A today and we ask that you use the chat feature to help submit questions to the presenters today. With that, I will turn it over to Bambi to kick us off with today's webinar with the agenda.

Bambi Cisneros:

Great. Thank you, Kristin. Good afternoon, everyone, and thanks for joining us today. As Kristin mentioned, today is our fourth installment in a series of public educational webinars that the Department has hosted to support the Long-Term Care Skilled Nursing Facility Carve-In transition to Managed Care. So, for today's webinar, our goals are to go through an overview of Medi-Cal Managed Care benefits, which include Basic Population Health Management, Complex Care Management, Enhanced Care Management, and Transitional Care Services. Then we will also review other Managed Care Plan benefits such as Community Supports, transportation benefits, and Skilled Nursing Facility specific services.

Bambi Cisneros:

Then we will also have an opportunity for Q&A in between sessions before the conclusion. So, this is what we hope to cover on today's webinar. Okay, we can go to the next slide please. Thank you. So, to orient or reorient us to why the carve-in is occurring, just as a quick reminder that the Long-Term Care Carve-In is part of CalAIM's Benefit Standardization Initiative. So, the goal of this initiative is to standardize coverage of benefits statewide. So, as you may be aware, we do have six different plan models of managed care here in the state. The notion is that we want the member's experience to be seamless and as least complex as possible should they move from county to county. So, their experience, we want that to be the as seamless as possible.

Bambi Cisneros:

So, that way, regardless of the county where the member lives, their Skilled Nursing Facility benefits will be the same. Also, under managed care members have access to a broad array of services such as comprehensive care coordination and care management, which we will talk about later today. These changes are being implemented in phases based on the Long-Term Care facility or provider type. So, our focus for today will be on the Skilled Nursing Facility coverage that implemented on January 1st earlier this year. Okay, next slide please. As I've mentioned, we do have different plan model types where we have Medi-Cal Managed Care, but Managed Care is available statewide in all 58 counties.

Bambi Cisneros:

This slide shows the plan model types by county. We did provide links here about which plans operate within the county as well as additional information on the different managed care models that we provided here on this link that you can browse at your leisure. Okay. So, Medi-Cal Managed Care Key Benefits: the Department contracts with Medi-Cal Managed Care Plans for the provision of healthcare services that is then delivered to our Medi-Cal beneficiaries. Managed care plans are required to offer medically necessary covered services, some of which are listed here. Skilled Nursing Facility residents in managed care will have access to the full set of benefits available through the health plan.

Bambi Cisneros:

So, today, we will review some of those key Medi-Cal managed care benefits that will be supportive for the SNF residents during their residence or that may also support them if they are transitioning from the SNF back to their home or community. So, we will be providing a high-level overview of the key care management levels and programs within the larger call CalAIM Population Health Management strategy, which includes Basic Population Health Management, Complex Care Management, Enhanced Care Management, and Transitional Care Services.

Bambi Cisneros:

Then we will also review dual eligible member care coordination, Community Supports, transportation benefits, and a review of the SNF services. So, with that, we'll go deeper

into the slides as we go along. I will transition this over to Laura to kick us off with Population Health Management. Laura.

Dr. Laura Miller:

Great. Thank you so much, Bambi. It's a pleasure to be here with all of you. So, we're going to start with an overview of Population Health Management, the program overview. As part of CalAIM, DHCS is establishing a standardized statewide approach to Population Health Management through which the Medi-Cal managed care plans are responsive to community needs and work within a common framework to improve outcomes and reduce disparities. Again, this is echoing what Bambi had mentioned about decreasing complexity and providing a standardized statewide approach. A cornerstone of CalAIM includes the expectation that starting in 2023, each plan will have and maintain a whole system person-centered Population Health Management program.

Dr. Laura Miller:

Beginning in 2023, all managed care plans will be required to meet NCQA Population Health Management standards and the PHM requirements will be phased in and we will roll out new PHM requirements gradually between 2023 and 2024. Many of the key elements are already in place in Medi-Cal, both via DHCS policies and each Medi-Cal plan’s Population Health Management programs, but we're trying to be more comprehensive and cohesive. So, the PHM program is a cohesive set of concepts and requirements that apply to all populations served by Medi-Cal Managed care. Next slide. So, we're going to talk about the CalAIM care management continuum.

Dr. Laura Miller:

Actually, this is one of the key slides here in that it really talks about the population as a pyramid, if you will. The highest need members are at the top and Enhanced Care Management or ECM provides intensive coordination of health and health-related services. For higher and medium-rising risk patients, there's Complex Case Management which provides ongoing care coordination, interventions for temporary needs, and disease specific management interventions, and then Basic Population Health Management. How are we taking care of all Medi-Cal members? This does include care coordination and comprehensive wellness and prevention programs. All of these of course require a really strong connection to primary care.

Dr. Laura Miller:

Anyone in any of these three categories can and should receive Transitional Care Services when they are transferring from one setting of care to another. So, hospital to skilled nursing, skilled nursing to home, et cetera. Next slide. So, I'm going to switch to talk a little bit about Basic Population Health Management now, that service that we hope that all Medi-Cal members across the state will have access to and that has indeed gone live. Next slide. So, the Basic Population Health Management program is actually integral to our vision in making improvements in health equity.

Dr. Laura Miller:

The Health Equity Roadmap within the Comprehensive Quality Strategy identifies the need to close the equity gap on select quality measures, including those related to preventive care and wellness that are part of the comprehensive quality strategy bold goals. Within that, the comprehensive quality strategy does discuss specific interventions promoting health equity, including new benefits, including the Community Health Worker Benefit and the Doula Benefit that provide culturally appropriate and community-based care, all of which needs to be evaluated by the plan under the Quality Improvement and Health Equity Transformation program. This is to ensure quality and equity outcomes.

Dr. Laura Miller:

The Basic Population Health Management program connects these activities and it is through the Basic Population Health Management program that plans will be responsible for deploying these programs. So, you can see here on the slide all of the key elements of Basic Population Health Management. Again, these are things that are not new, many are included in NCQA Population Health Management standards. However, DHCS has not previously articulated them as a comprehensive package of programs and supports, which we now are doing. Next slide. So, now we'll move on to a discussion of Complex Care Management and we'll just bring that slide up.

Dr. Laura Miller:

So, Complex Care Management, we really want to develop a common terminology and expectations that apply across populations for those who need care management and establish a continuum of care approaches between Enhanced Case Management and Complex Care Management. So, it's equivalent to Complex Case Management as defined by NCQA. CCM is really appropriate for higher risk and medium and rising risk members. It includes chronic care management and interventions for temporary and episodic needs, and it must include comprehensive assessment and adhere to all of the NCQA related requirements. Medi-Cal plans can absolutely use their own staff as care managers. So, those are some of the elements here.

Dr. Laura Miller:

You'll notice that there's an ECM, which we'll talk about in a moment. There's a great emphasis on community-based organizations as care managers, but for Complex Care Management, plans may use their own staff. Next slide. So, as I stated, we'll now move on ECM or Enhanced Care Management. Next slide. I think this is one of my favorite programs if I have to have a favorite. ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that often engage multiple delivery systems to access care, including primary and specialty care, dental, mental health, substance use, and long-term services and supports.

Dr. Laura Miller:

Again, these are our highest need folks, our most fragile folks, and those who are having to navigate multiple systems that are definitively hard to navigate. So, ECM is

designed to address both the clinical and nonclinical needs, which I think is incredibly important. Those nonclinical needs, the social determinants, the social drivers, have a huge impact on health status as we know. In ECM, there's intensive coordination of health and health-related services. Really, it's meeting people where they are, on the street, in a shelter, in their doctor's office, at home, moving out of our offices, out of where we make patients come to us and actually taking care of them where they are.

Dr. Laura Miller:

ECM is part of a broader CalAIM and Population Health Management system design through which plans offer care management interventions at different levels of intensity based on member need. As I stated, ECM is the highest intensity level. So, there are multiple core services within ECM including outreach and engagement, comprehensive assessment and care management, enhanced coordination of care, coordination and referral to community resources, member and family supports, health promotion and comprehensive transitional care. I think really all the key elements are incredibly important to meeting people where they are and helping them live their best lives. Next slide.

Dr. Laura Miller:

So, there are two new Populations of Focus that have come live January 1st, which I find really exciting. The first that we'll talk about are adults who are living in the community who are at risk for long-term care institutionalization, essentially frail folks who really are sick enough to need skilled nursing. So, they meet the SNF level of care criteria or they require low acuity skilled nursing such as time limited or intermittent nursing services for prevention, diagnosis, or treatment of an acute injury. They're experiencing at least one complex social or environmental factor influencing their health. These could be things like needing assistance with activities of daily living, communication difficulties, access to food, stable housing, living alone.

Dr. Laura Miller:

Isolation as we know with COVID has a tremendous impact. The need for conservatorship, guided decision making, poor or inadequate caregiving that may appear as a lack of safety monitoring. Basically, when I think about my patient panel, everybody's got at least one of those factors and the folks eligible for this population are able to reside in the community if they have support. So, if we can meet their needs with community resources in ECM and Community Supports to have them safely stay in community, that is what we want. So, the braiding of all of these resources and services is incredibly important. Next slide. So, again, this is a few more notes on the definition. Again, these are folks who are at risk for long-term care institutionalization.

Dr. Laura Miller:

Folks who meet this Population of Focus may live in independent housing, in Residential Care Facilities, in RCFEs, the Residential Care Facilities for the Elderly, or any other dwelling that meets Home and Community-Based Services Final Rule. People who are excluded are folks who are in Intermediate Care Facilities or Subacute

facilities. Below you can see multiple links to both the California Code of Regulations as well as other eligibility criteria. As noted, these slides all have links including to the ECM policy guide. Next slide. So, this is the second Population of Focus that went live in January. These are nursing facility residents transitioning to the community. So, frail folk, patients who are living in SNF, residing in a SNF and want to transition to community.

Dr. Laura Miller:

So, these are people who are interested in moving out and are likely to do so successfully and able to reside continuously in the community with the supports as outlined. So, in terms of the definition, able to reside continuously in the community means people who are transitioning to the community, they may need to return to hospital or SNF for short admissions. That is something that absolutely could happen, but we don't want to preclude them from being considered. So, if somebody is having chemotherapy that's going to have intermittent complications and may need to go back to hospital, that does not exclude them from being in this Population of Focus.

Dr. Laura Miller:

As stated with a prior [slide], people living in ICFs or subacute care facilities are excluded from this Population of Focus. Again, one of the things we've heard is that people may be interested in moving out of the Skilled Nursing Facility, but there's not any uptake on the other side to support them doing that. So, having this population be an ECM Population of Focus, we're really helping giving people the support they need to move out of skilled nursing and back into the community. Next slide. So, how do people access the ECM benefit? Members who qualify might be contacted directly by their health plan or a community support provider. The plans themselves are responsible for identifying members who may benefit from ECM and who meet the criteria.

Dr. Laura Miller:

Once a member's identified, the health plan or their ECM provider may contact them to discuss the ECM and that's fantastic. In some cases, providers like an ECM provider may know that somebody is wanting to come out of SNF. Certainly, the plans can submit referral for members. If they appear to meet the requirements, they can submit a referral to the health plan and members can self-refer. They can ask for information if they qualify. Next slide. So, briefly, I'm going to move on to Transitional Care Services here. Next slide. This is really about when a member is transferring from one setting or level of care to another. It includes but not limited to discharge from hospitals, acute care facilities, skilled nursing, and any other Long-Term Care settings.

Dr. Laura Miller:

So, the goals for transitional care are so that members can transition to the least restrictive level of care that meets their needs. I think that's very important in terms of just human dignity, that care setting is aligned with their preferences in a timely manner and without interruptions in care. Members receive the support and coordination they

need to have a safe and secure transition with the least burden to the members possible and they continue to have needed support and connections to services to make them successful in their new environment. Next slide. So, this is a slide on the Medi-Cal Managed Care Plan Population Health Management requirements with regard to Transitional Care Services.

Dr. Laura Miller:

The top three are plan responsibilities, so knowing when a member is admitted, discharged, or transferred, processing prior auths, and notifying the case manager. Then the case manager functions are in the four below, and the function can reside at the provider level for sure. These care manager functions, discharge risk assessment, information sharing, and discharge planning, follow up – there's a lot in here in terms of medication reconciliation, close group referrals, all of the nitty gritty of really doing high quality care and then seeing if that person might need other supports including Enhanced Care Management, Complex Care Management , and Community Supports. Next slide.

Dr. Laura Miller:

So, this is briefly new policy guidance on phased transitional care implementation. So, as of January 1st, just a little bit ago, plans must ensure that all Transitional Care Services are complete for high-risk members, and then by January 1 of 2024, transitional care will be required of the plans for all members. So, it's high-risk members now and that's defined in the Population Health Management Policy Guide and then all members by 2024. Next slide. I think this means I pass it to another friend. I think it's back to you, Bambi.

Bambi Cisneros:

Great. Thank you so much, Laura. The battery of my mouse is dying, so I'm like, "Wait." Thank you so much for that presentation and walking through the requirements, Laura. So, I think next what we'll do is briefly review care coordination for dual eligible beneficiaries and Medicare Medi-Cal plans or what we're calling MMPs, Medi-Medi Plans. So, we can go on to the next slide please. So, this slide talks about dual eligible beneficiaries, which are individuals who have both Medicare and Medi-Cal, which we often refer to as Medi-Medis. Duals are more likely than non-dual Medicare beneficiaries to report being in poor health and more likely to live in an institution. The majority of beneficiaries with Medi-Cal residing in Skilled Nursing Facilities are dual eligible individuals.

Bambi Cisneros:

So, we know that for most dual eligible beneficiaries, Medicare and Medi-Cal operate separately and with different funding streams. So, for dual eligible beneficiaries with high rates of chronic conditions and functional impairments, streamlined access to services across health, healthcare, and long-term care services and support systems is especially important for this population. Now we'll go on to the next slide please. So, 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, which were known as the Coordinated Care Initiative or CCI counties. Cal MediConnect sunset on December 31st, 2022.

Bambi Cisneros:

Then on January 1st, 2023, beneficiaries in the Cal MediConnect plans were then automatically transitioned into a Medicare Medi-Cal plan or MMP or Medi-Medi Plan, which means that it's operated by the same parent company as the Cal MediConnect plan. We can go on the next slide please. So, Medi-Medi Plans, which are also known as Exclusively Aligned Enrollment Dual Eligible Special Needs Plans are a type of Medicare Advantage plan in California that are only available to dual eligible beneficiaries. Beneficiaries enrolled in a Medi-Medi Plan receive their Medicare benefits through a Dual Eligible Special Needs Plan or D-SNP and their Medi-Cal benefits through a Medi-Cal Managed Care Plan.

Bambi Cisneros:

D-SNPs are a type of Medicare Advantage plan that provides hospital services, primary care providers, and prescription drugs. D-SNPs offer specialized care for dual eligible beneficiaries. These Medi-Medi beneficiaries are enrolled in a D-SNP as a Medi-Cal Managed Care Plan of the same organization and we call this a matching Medi-Cal plan. Then the Medi-Cal plan then provides wraparound services, including the cost sharing for Medicare, long-term services and supports, and durable medical equipment. The Medicare and Medi-Cal plan of a D-SNP are operated by the same parent organization in order to provide better care coordination and integration.

Bambi Cisneros:

So, wanted to emphasize here that the members' Medicare benefits are not changed or affected by the Long-Term Care SNF carve-in transition as we've talked about on all of these slides. We can go to the next slide please. In CCI counties, members in CalConnect plans transitioned into Medi-Medi Plans on January 1st, 2023 as I had mentioned. Dual eligible beneficiaries who are not Cal MediConnect members had the option to enroll in a Medi-Medi Plan in CCI counties. So, it was voluntary. Additionally, individuals eligible for Medicare retained the choice of enrolling in other Medicare options. Those options include original Medicare, Medicare Advantage plans, or the Program of All-Inclusive Care for the Elderly or PACE plans.

Bambi Cisneros:

Currently, Medi-Medi Plans are available in the formerly Coordinated Care Initiative counties, which are in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. On to the next slide please. Medi-Medi Plans provide certain services to beneficiaries and enumerated here on the slide, which include all Medicare covered services, and all Medi-Cal covered services. There's some additional supplemental benefits that are over and above the original Medicare and Medi-Cal benefits, as well as coordination with carve-out benefits similar to what was

provided under Cal MediConnect and also one care management team to help coordinate care and help a beneficiary manage their services.

Bambi Cisneros:

So, on this slide, for individuals in a Skilled Nursing Facility, Medi-Medi Plans will help beneficiaries with all of their healthcare needs. So, that means helping beneficiaries coordinate benefits and care including services that are carved out, medical and home and community-based services, DME, and prescriptions. Okay. So, I think at this point, we will pause and take questions on the segment that we just went over pertaining to the various levels of care management programs and the duals care coordination. So, I think at this point, Kristin, I'll turn it over to you.

Kristin Mendoza-Nguyen:

Great. Thank you, Bambi. Thank you, Laura, for your presentations. There were a few questions that came in during the registration for the webinar, so I wanted to just kick off with those. There were a few that came in about hospice services. So, how will the SNF LTC carve-in affect hospice services and benefits? I think this might be a question maybe Bambi for you.

Bambi Cisneros:

Sure, yeah. The hospice services are a Medi-Cal covered benefit already today, even before the transition. So, there should not be any changes or impact to hospice services with this carve-in as well.

Kristin Mendoza-Nguyen:

Great. Then how can authorized representatives help beneficiaries enroll in a Medi-Cal Managed Care Plan?

Bambi Cisneros:

Yeah, I think we have them on these slides, but we do have listed resource information for Health Care Options who is the department's enrollment broker as well as the DHCS Medi-Cal Ombudsman who can also help members facilitate plan choice and enrollment.

Kristin Mendoza-Nguyen:

Okay, great. I know we received a number of questions in the chat. I think this question coming up, it was from Lindsay, it probably applies to ECM. So, Laura, this might be a question for you. Does meeting people where they are apply to people currently living in SNFs who are not transitioning in or out?

Dr. Laura Miller:

So, really the meeting people where they are language comes from ECM. So, I think one of the crux of the matter is we don't necessarily always know if somebody wants to transition out of a Skilled Nursing Facility. So, when a case manager from a plan is

reviewing the data for utilization management purposes for somebody in skilled nursing, they can certainly ask that question, "Does the person want to transition out?" and then activate a referral to ECM.

Dr. Laura Miller:

One of the challenges we've heard from the skilled nursing advocate world is that there are folks in skilled nursing who do want to get out and don't have anybody really outreaching to them. So, I hope that answers your question. I'm not entirely sure it did, but essentially, anybody can be referred in and then there will be an evaluation process.

Kristin Mendoza-Nguyen:

Okay, great. Thank you. A question from Reanna, can you please provide guidelines on the timeframe that is considered timely manner for authorizations?

Dr. Laura Miller:

Yeah, so I'm reaching back to my prior experience as a CMO within managed care land. Timely for outpatient authorizations is 72 hours for urgent and five business days for a standard authorization. So, I'm not sure if that gets at your question. Some of it is laid out in the managed care contract. So, that will probably have data there as well and we can certainly get back to you if more specificity is needed.

Kristin Mendoza-Nguyen:

Okay. There's a question on Denti-Cal benefits. How does the SNF Carve-In to Managed Care affect Denti-Cal benefits and for who providers for Denti-Cal? Maybe a question for Bambi.

Bambi Cisneros:

Sure. So, the transition does not implicate any changes to the dental benefits or the ability of providers to work with a Medi-Cal dental. So, I don't know if you have specific questions about the SNF carve-in and how it particularly pertains to you, but there should not be any changes.

Kristin Mendoza-Nguyen:

Okay, great. There was also a question about HCBS waiver programs. Can you speak to that?

Bambi Cisneros:

Oh, yes. I think I tried to respond to that questions in the chat as well. So, there's no changes to Home and Community-Based Service waiver programs. They will remain carved out.

Kristin Mendoza-Nguyen:

Okay. Then a follow up to the hospice question. “So, we understand hospice is already a benefit, but will this service be coordinated or case managed? Does the plan decide which beneficiary is eligible or appropriate for hospice care”? Question from Brenda.

Bambi Cisneros:

Perhaps Laura too from a clinical perspective may have more to add too, but I mean it is a person-centered decision between the provider, the member, and the family and also part of the plan's transitional care and care coordination, care management processes. So, I would say it's very member specific and I don't know if, Laura, you may want to add.

Dr. Laura Miller:

Yeah, I mean it is very much member specific. In all my experience with hospice, the definition of hospice eligible is, "Would a reasonable person think they have six months or less to live?" But I think it's going to vary from person to person.

Kristin Mendoza-Nguyen:

A question about Transitional Care Services, Laura, you mentioned a TCS care manager can be at the provider level. What provider are you referring to as members go to the hospitals all over that are contracted or non-contracted?

Dr. Laura Miller:

Yeah, so you're right, that language is a little bit vague. It can be with the facility where the patient is, it can be through ECM, it can be through primary care, but that's the intent there.

Kristin Mendoza-Nguyen:

Okay. Let's see. A question about two-plan counties specifically from Erin. How is the transition in non-CCI counties from SNF and LTC going two-plan model counties? Are MCPs able to provide the coverage of these clients or is it in process and is there a timeframe?

Bambi Cisneros:

Yeah. So, the Long-Term Care Skilled Nursing Facility benefit is now statewide. It was in COHS and CCI counties, but the Carve-In that occurred on January 1st, 2023 made that be statewide including the non-COHS counties. I wasn't sure if you had further questions about that.

Kristin Mendoza-Nguyen:

Okay. All right. I think that wraps up our questions for this first Q&A. We'll have another one at the end, so there'll be more time. With that, I will turn it over to Shel to present on Community Supports.

Shel Wong:

Thank you. So, if we can go to the next slide. So, Community Supports are services or settings that Managed Care Plans can elect 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. Managed Care Plans are strongly encouraged but not required to provide these services. So, Community Supports are designed as cost-effective alternatives to traditional medical services or settings and to address social drivers of health, those factors in people's lives that influence their health. I do want to flag that different Managed Care Plans can offer a different combination of Community Supports in the counties where they operate.

Shel Wong:

So, the DHCS ECM Community Support's website does have a list of the various Community Supports offered by each managed care plan in their counties. While Managed Care Plans must follow DHC'S standard Community Support service definition, they may also make their own decisions about whether it's cost effective and medically appropriate to use Community Supports. So, one thing I do want to flag is that Community Supports are not restricted to the ECM Populations of Focus but are actually available to all members who meet the eligibility criteria for that specific Community Support. We can go the next slide. So, this is a list of the 14 pre-approved Community Supports.

Shel Wong:

As I mentioned, that first eligibility is for anyone who meets the service definition eligibility and not just the Community Supports definition. So Managed Care Plans are strongly encouraged to offer one or more of these Community Supports listed and information about each specific Community Support can be found in the Community Supports Policy Guide, which is linked at the bottom of the slide. Next slide please. So, Community Supports for members in the Long-Term Care Population of Focus.

Shel Wong:

So, the Community Supports that are especially applicable to members in Long-Term Care settings such as SNFs include the nursing facility, transition, or diversion to assisted living facilities, Community Transition Services or nursing facility transition to a home, environmental accessibility adaptations, also known as home modifications, respite services and personal care and homemaker services. But once again, people who are in Long-Term Care settings may be eligible for more Community Supports if they meet the eligibility criteria. Then if we can go onto the next slide, I can talk a little bit about how do members access Community Supports.

Shel Wong:

So, similar to ECM, there are three ways that Managed Care Plan members can access Community Supports from their Managed Care Plan. So, first, members who qualify may be contacted directly by their Managed Care Plan or a Community Supports provider. Second, a health or social services provider or any provider really, can submit

a referral to the plan on behalf of the members. So, they don't have to be an ECM or Community Supports provider. It can be any provider that sees the member.

Shel Wong:

Thirdly, the member can self-refer or ask for more information from the Managed Care Plan to see if they qualify for Community Supports that are available in their area. So, the easiest way for them to do that is to contact the number on the back of their insurance card. There's also information on the MCP websites about ECM and Community Supports. With that, I'm going to transition it to Bambi to talk a little bit about transportation benefits.

Bambi Cisneros:

Okay, great. Thank you, Shel. So, we will move on to transportation benefits under Managed Care and we can go to the next slide please. Okay, thank you very much. So, Medi-Cal offers transportation to and from appointments for services that are covered by Medi-Cal and this includes transportation to medical, dental, mental health, or SUD appointments and to also pick up prescriptions and medical supplies. In Medi-Cal, we do have two different types of transportation that is covered specifically under Medi-Cal Managed Care. It really depends on the member's ambulatory level.

Bambi Cisneros:

So, the first transportation benefit is Non-Emergency Medical Transportation or NEMT. This is transportation that's provided via ambulance, wheelchair van, or litter van and really for beneficiaries who can't use public or private transportation to get to and from their covered medical services. So, NEMT is available to all beneficiaries when their medical and physical condition doesn't allow them to travel by public or private transportation such as bus, car, taxi, et cetera. Managed Care Plans are responsible for covering NEMT for medically necessary covered services. The second modality of transportation is Non-Medical Transportation or NMT. This is transportation that is provided through private or public transportation.

Bambi Cisneros:

So, there could be various reasons why a beneficiary would need an NMT and it could include not having a valid driver's license, not having a working vehicle, having physical, cognitive, mental or developmental limitations or no money for gas to get to an appointment. So, because there are two different sets of transportation modalities, we do have providers work closely with their Managed Care Plans to understand the transportation request process, because for NEMT, prior authorizations are required, and then for NMT, Managed Care Plans contract with different transportation vendors.

Bambi Cisneros:

So, they have policies and procedures to ensure that members do get timely access to their appointments that also meet their member needs. So, we added as a link here on the slide an FAQ that has further details delineating both modalities of the transportation

benefit. Then we can go to the next slide please. Okay. So, I think at this point I will turn it over to Beau to talk about the Skilled Nursing Facility services specifically. Thanks.

Beau Bouchard:

Thanks, Bambi. Yeah. Okay, before I get into these slides, I will just make a caveat that our Benefits Division partners were not able to make the call today. So, if anyone has any specific questions to these next few slides, the team is going to be taking those back in order to get responses to you all in writing. So, if we want to hop in, next slide please. So, included SNF services within the SNF per diem rate. So, rates for the Long-Term Care facilities include all supplies, drugs, equipment, and services necessary to provide a designated level of care. A few examples of inclusive items include room and board, nursing and related care services, personal hygiene items, and routine therapy services.

Beau Bouchard:

For the routine therapy services, federal law states that each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practical physical, mental, and psychological wellbeing in accordance with the comprehensive assessment and plan of care. So, in many cases, however, these therapy services can and should be performed as part of the nursing facility inclusive services which is covered under the facility's per diem rate and therefore not separately reimbursed. Medi-Cal plans must pay for all SNF levels of care, including custodial care, the Skilled Nursing Facility care, and intermediate care. Next slide please.

Beau Bouchard:

To provide more clarity and expand on therapy services, it's important to understand that routine therapy services are services that are covered under the per diem rate. This includes therapy services that are needed to maintain a patient's current functionality.

Beau Bouchard:

Therapy services provided to the recipient that are covered by the per diem rate include but are not limited to keeping recipients active and out of bed for reasonable periods of time except when contradicted by a physician's order, supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient, and care to prevent formation and progression of decubiti, contractures and deformities, including changing position of bedfast and chair fast recipients, encouraging and assisting in self-care and activities of daily living, maintaining proper body alignment and joint movement to prevent contractures and deformities.

Beau Bouchard:

These routine therapy services would be subject to the directed payment policy that's outlined under APL 22-018. Next slide please. So, for the exclusive SNF services or outside of the per diem rate, services outside the per diem rate are not subject to the directed payment policy and would follow the normal MCP and provider negotiation process. This means that for patients that require any services outside of the per diem

rate, the SNFs and MCPs must negotiate payment for those services separate and outside of the per diem rate. Again, DHCS does not get involved with MCP and provider negotiations. Some exclusive items are separately reimbursable and subject to utilization review controls and limitations of the Medi-Cal program.

Beau Bouchard:

Exclusive items are items not included in the per diem rate and could include supplies, drugs, equipment, or services. Some examples of these items include allied health services ordered by the attending physician, dental services, durable medical equipment with exceptions listed under 22 CCR 51321 (h), insulin, laboratory services and X-rays, legend drugs, and wheelchairs unless the beneficiary demonstrates the need for a custom wheelchair under CCR 51321 (h) or when a custom mobility device is necessary for the beneficiary to attain or maintain the highest practical, physical, mental, or psychosocial functioning in accordance with the comprehensive resident assessment and individual plan of care.

Beau Bouchard:

Also, notating that there are a more exhaustive list of excluded services within the Medi-Cal provider manual. Next slide please. In instances where a patient requires therapy services that are no longer considered routine and are defined as per diem exclusive services, MCPs and a SNF can negotiate payment for such services that are outside of the directed payment. For these exclusive services, a physician must determine if a patient first requires intensive therapy or therapy beyond the routine or normal course typically provided in order to maintain the highest practical, occupational, mental, and psychosocial functioning in accordance with their individualized plan of care.

Beau Bouchard:

Some examples of exclusive services include many occupational, physical, and speech therapies such as ongoing occupational therapist's involvement to conduct periodic assessments of the patient and evaluation of the patient specific treatment plan. A physical therapist trained staff on a recipient plan of care that states the beneficiary who has, say, suffered a stroke, needs hemislings to prevent shoulder subluxation and a hand splint to prevent muscle contracture and deformity in the hand. Speech therapy for a post-stroke patient who is dysphasic. Further details regarding exclusive services not covered under the per diem rate are available at TAR Criteria for NF Authorization. So, I will hand this over to Kristin if you want to open it up with questions.

Kristin Mendoza-Nguyen:

Great. Thank you, Beau. Thank you, Bambi and Shel for your presentations. There was an earlier question on Community Supports. So, this question is for Shel. There were a few. The question from Julie, if someone is on a hospice or getting HCBS services, can they access Community Supports if they qualify?

Shel Wong:

Yeah. So, ultimately, it's up to the Managed Care Plans to determine if it would be medically appropriate and cost-effective for the member to receive the Community Supports. But as long as the services are not duplicative of what they're currently receiving, they may be able to qualify.

Kristin Mendoza-Nguyen:

Okay, great. There was a comment from Sarah. We have heard there is a wait list for Community Supports, for example, for housing services. If there are instances where there's wait lists, what can providers do to help get access or expedite reviews if possible?

Shel Wong:

Yeah, so what we've heard is that a lot of Managed Care Plans are still working on bringing up their provider capacity to serve all the eligible members within their counties. So, in terms of wait lists, Managed Care Plans do have processes in place that are supposed to help to mitigate those wait lists. But we would want to hear from DHCS if you are encountering any of those wait lists so that we can see if there's any technical assistance we can provide. The other thing is just working with the Managed Care Plans to make sure that all of the required information for authorizations are available so that they can conduct timely reviews.

Kristin Mendoza-Nguyen:

Okay, great. Thank you. Let's see. I know there were a number of earlier questions on Denti-Cal. I think Bambi had noted we'll take those back to share responses in writing. I don't see any new questions but I'll give folks some time. I know there was a lot of information. We've been trying to answer questions in the chat as we've been going as well. There was an earlier question from Jessica, specifically on dual eligible members, “Will it be required to request authorization for Medicare co-insurance or can we bill a Managed Care Medi-Cal plan without authorization?” Bambi, it might be a question for you or I'm not sure if we need to take that one back as well.

Bambi Cisneros:

Sorry, Kristin, would you mind repeating that?

Kristin Mendoza-Nguyen:

Yeah, so it was a question from Jessica and it is on dual eligibles, “Will it be required to request authorization for Medicare co-insurance or can we bill the Managed Medi-Cal plan without authorization?”

Bambi Cisneros:

Yeah, I know there's coordination of benefits policy that's being circulated and I don't want to give out incorrect information. So, why don't we take that one back and we can respond in writing to that particular question?

Kristin Mendoza-Nguyen:

Sounds good.

Steph Mahler:

Kristin, just to jump in, there's really great fact sheets on the DHCS website for billing for our dual population, so I can put that in the chat.

Kristin Mendoza-Nguyen:

Okay, great. Thank you, Steph. Okay, I don't see any new questions coming in the chat. I know there was just a general comment about additional resources to ensure that SNFs and other providers are aware of what items, including what we covered today. They're supporting the clients and the members to access the appropriate services. So, we can definitely follow up and share additional resources and fact sheets as well. With that, I will turn it to Bambi to close us out, then, today.

Bambi Cisneros:

Yeah. Thanks so much, Kristin. Also, because I know we have fact sheets for ECM and Community Supports as well, so I think that would be good to share out with this group as well and also probably the link to these previous... Oh, that's already here. .... carve-in webinars because I see that some people had missed the previous webinars in this series, so I'm sharing that here. So, our final webinar is on February 24th. We've had a series of these since September and we hope for those who were able to join us that you found them informative and helpful. We are sharing the link here that does have materials from those previous webinars as well as information on the upcoming webinar, including the registration links, onceavailable.

Bambi Cisneros:

Then also the next slide also has some resources as well. We do have APL 22-018, which is our guidance to our Medi-Cal Managed Care Plans on the SNF policy as well as FAQs and other resources. So, wanted to share that as well and wanted to take this opportunity on behalf of the Department to thank you for attending today's webinar and for your participation. We do have some follow-ups here and so we will gather internally and we'll send this back out to you all as well. Thank you for your time. Have a good day.