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 morning, everybody. We're just going to give everyone a minute to trickle in from the waiting room. I know there's a large group joining us today. My name is Kristin Mendoza-Nguyen. I'm from Aurrera Health Group. We'll be supporting DHCS on this effort today. Welcome to today's webinar. It is the CalAIM Skilled Nursing Facility Carve-in Long-Term Care 101 for Managed Care Health Plans. We are delighted that you were able to join today for this kickoff of this webinar series. We have some great presenters with us today that will be helping us. Bambi, the Assistant Deputy Director from Healthcare Delivery Systems at DHCS; Stephanie Conde, Branch Chief in Managed Care Operations Divisions at DHCS; Stephanie Mahler, Clinical Network Liaison; and April Watson, the Interim Provider Service Director at the Health Plan of San Mateo.

Kristin Mendoza-Nguyen:

Just a few meeting management items to note before we start. Next slide, please. All participants will be on mute during the presentation. Please feel free to submit any questions you have for speakers via the chat. During the discussion, if you would like to ask a question or provide comments or feedback, please use the raise the hand feature, and we will unmute you. The materials were emailed beforehand and will also be posted on the website as well. And we'll share that link in the chat.

Kristin Mendoza-Nguyen:

And just a brief logistics, housekeeping item, we ask that you guys take a minute to add your health plan name to the side of your name. If you hover over your participant attendee list and you can rename yourself, it helps with the facilitation of the questions as well. And then lastly, just a few additional items. Next slide. The webinar today is being recorded and it will be shared as a resource for all of you. And again, everyone is muted, but they will be unmuted during Q&A using the raise hand feature. And please do use the chat throughout, we will be unmuting and monitoring that as well. And so with that, without further ado, I would like to turn it over to Bambi, to kick off the webinar today.

Bambi Cisneros:

Great. Thank you so much, Kristin. Good morning, everyone. I'm Bambi Cisneros. I'm the Assistant Deputy for Managed Care here at the Department of Health Care Services. And I wanted to thank everyone today just for your time with us this morning, where we talk about the Long-Term Care carve-in and specifically about Skilled Nursing Facilities. And so for today, what we wanted to cover is just some quick background and overview on the Long-Term Care carve-in as part of the CalAIM proposal, and then we'll get into the actual carve-in policy requirements for Skilled Nursing Facilities. And then I'll turn it over to Stephanie to talk about our plan for member communications and what we're planning on doing for data sharing with our Managed Care Plans.

Bambi Cisneros:

And then we have our presentation today from the Health Plan of San Mateo who has experience in this space. And so they wanted to talk to you about how plans can prepare and offer some advice and some promising practices. And then we'll have some wrap-up at the end with Q&A. One thing I wanted to point out is that, at the end of each of these segments, we'll have an opportunity to have kind of a Q&A session as well. And we can also have that at the end. So, I just want to make sure that we address your questions and concerns, and so we want to provide opportunity for the discussion there. Okay?

Bambi Cisneros:

So, we can talk a little about CalAIM, and by now I'm sure you're all very well versed in CalAIM, which is the Department's multi-year plan to really transform Medi-Cal, and so we have a lot of these really transformative and innovative policies. And specifically, CalAIM includes efforts to carve-in Long-Term Care to Medi-Cal Managed Care statewide. And this is part of an overall shift to Managed Long-Term Services and Supports beginning in 2027 is what you have probably seen described in the CalAIM proposal. And so the ultimate goal for implementing MLTSS statewide is really to allow members to receive the needed Managed Long-Term Services and Supports and any home and community-based services statewide through their Managed Care Plan. Because currently today, how that's provided is through various 1915(c) or Home and Community Based Services waivers.

Bambi Cisneros:

And so, it's not statewide and there's enrollment caps, there's certain criteria that members have to meet. And so the whole idea and one of the goals of CalAIM is to really standardize the member experience and having the same suite of benefits across the board. And so in turn, specific to the Long-Term Services carve-in, there would be many benefits which would include improved care integration, person centered care , and then building on lessons and success of Cal MediConnect and the Coordinated Care Initiative, or CCI. And then ultimately, it supports the Governor's Master Plan for Aging. And so, these are just some of the benefits, and I'm sure you're all well aware because this is really dependent on the managed care model. So thanks for being our partners on this and apologies for the background noise. Hopefully, it's not too distracting. Okay. I think we can go onto the next slide.

Bambi Cisneros:

So, the current state today, is that in COHS and CCI counties, Long-Term Care services are carved in. What that means is that plans that are in those counties are responsible for all medically necessary Long-Term Care services, regardless of the length of stay in a facility. So, if members require long-term stays at nursing facilities, they will continue to stay enrolled in the plan to continue to receive those services, and they do not transition to Fee-for-Service. So, Cal MediConnect and Managed Care Plans coordinate

the members' care with the Long-Term Care facilities and other services, which is one of the great benefits of having a Managed Care Plan organization.

Bambi Cisneros:

This slide lists the COHS and CCI plans that have Long-Term Care carved in today. So, they already cover Long-Term Care as a managed care benefit. For these COHS and CCI counties, they will not really be impacted by the January 1, 2023 carve-in date, since they already provide these services today. So, now we'll talk about the plans that are in a Non-COHS or Non-CCI plan model county in today's environment. And so in today's environment, in other counties that are... In other plan model types that are not COHS or CCI, plans are responsible for Long-Term Care services provided from the time of admission into a long-term care facility and the following month. And so if the member requires Long-Term Care services in a facility longer than two months, plans are then required to disenroll the member and then coordinate their transition to Fee-for-Service. And in the meantime, while that is all happening, the plans are required to provide all medically necessary covered services to the beneficiary as they work to transition their care. And so that's what it is today.

Bambi Cisneros:

We can go to the next slide. So, what are the changes happening to make Long-Term Care statewide come 2023? Well, we're taking a phased approach to implement the changes based on the facility type. For January 1, 2023, the Department is making the Skilled Nursing Facility benefit available statewide. And then on July 1, 2023, the Department will carve in the Long-Term Care benefit for adult and pediatric subacute facilities, as well as the Intermediate Care Facilities that are listed here. So, there's kind of the various levels of ICF/DDs, the ICF/DD-H (habilitative) and ICF/DD-N (for nursing), those will go at a later time, on July 1, 2023. And so, what I would say is the focus of our presentation today is really about the Skilled Nursing Facility carve-in, in preparation for January 1, 2023. Can we go to the next one.

Bambi Cisneros:

Just reorienting the goals for carving Skilled Nursing Facilities statewide, which really aligns with the overall goals of CalAIM and the statewide MLTSS that we had talked about. This is part of the benefit standardization initiative, part of CalAIM, which means that benefits and coverage will need to be standardized across the state regardless of plan model. And so, the idea is, regardless of the county that the member lives in, their benefits would remain the same. Which would, of course, avoid disruption when the member needs to be enrolled to Fee-for-Service, and offers the care coordination that plans do offer today. And so we really do believe in the managed care model and the services it provides such as access to care, care coordination, care management, and the full array of services. And so, we just wanted to reorient to the goals as to our “why.”

Bambi Cisneros:

As we talked about in previous slides, the crux of the change is really that starting January 1, 2023, all Managed Care Plans will cover Skilled Nursing Facility services, which would make Skilled Nursing Facility services a statewide benefit across all the plan models statewide. So, that means that beneficiaries that would enter a Skilled Nursing Facility, and would otherwise have been enrolled from the plan, will remain enrolled in the plan in order to continue getting those services. And so in addition to that, all Medi-Cal only, and dual eligibles in Fee-for-Service that are residing in a SNF on January 1, 2023, will be enrolled in a plan. And so, we're estimating the impact to be about 28,000 members statewide. Next, we'll get into Long-Term Care services and what that consists of, and what may be excluded from Long-Term Care services. Sorry, can you hear me okay?

Kristin Mendoza-Nguyen:

Your audio's good. I can hear you.

Bambi Cisneros:

Okay. Thank you. Long-Term Care services really is care that's provided in a Skilled Nursing Facility, Intermediate Care Facility, or Subacute Facility. And the specific types of facilities are listed on the slide. A Skilled Nursing Facility refers to a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. Really, those SNF residents are those that require medical or nursing care or rehab services, for rehab due to injury, disability, or illness. Next, we'll get into the Long-Term Care services as part of the per diem rate. So, rates for Long-Term Care facilities include all of the supplies, drugs, equipment, and services necessary to provide a certain level of care, and these include the cost for those personal hygiene items, and therapy services, for example. There are some standards and requirements that are specified in regulations in the Medi-Cal provider manual, which then say that Managed Care Plans are obligated to cover all of the Skilled Nursing Facility levels of care. And we did add here, on this slide, the link to the provider manual, just for background and resource.

Bambi Cisneros:

And of course, there are some things that are not included in the per diem rate and for those types of services, they would be separately reimbursed. And those items are also specified in the provider manual, and include things such as dental services, durable medical equipment, or DME, and lab services, and X-rays. And again, providing the link here to the provider manual for your background and resource as well. Now we will get into the policy and the requirements specific to Skilled Nursing Facilities, and go through some of the key APL elements. We did send out the draft APL for comments. We're reviewing those and making some edits based on the feedback we've received, so thank you for sending those. So, I think a lot of you will be very familiar with the policy that we're describing here. The first thing, and we can get to the next slide, is about leaves of absence and bed holds.

Bambi Cisneros:

For this, there's certain member protections for members residing within a SNF that plans need to be aware of. One of those pieces is really compliance and adherence with a Leave of Absence, or what is also called a Bed Hold policy, and those requirements are specified in regulations in the state plan. Bed Holds are those periods of time when the member, who's a resident of the facility may leave the facility, and then what happens is they have return rights to the facility. And so, for that part of the policy, plans may require prior authorization. But really, the policy is intended to protect the member should their care setting change temporarily. Ultimately, the goal is that there's continuity in care. So, again, I think a lot of these requirements, I would say, were lifted from the provider manual and/or regulations. And so, towards the end of the slide deck we did provide links to the provider manual if you wanted to delve into additional information there.

Bambi Cisneros:

We can go to the next slide. So, what are plans required to do in order to comply with the Bed Hold requirement? Well, there's certain things the plans must do, and that is to allow members to return to the same SNF where the member was previously residing under this Bed Hold policy. They need to ensure that the Skilled Nursing Facility itself notifies members of this policy and explains the member rights to the Bed Hold provision. Members must also receive transition assistance and care coordination if there is an exception, or if a SNF fails to comply with regulations. So, this is something that the plans do today is they coordinate the member's care and transition out to other services, so we would expect that to continue. And also if there are denials of Bed Holds, that the plans do look at those, and address the concern to ensure that members do get the appropriate access.

Bambi Cisneros:

So next, let's talk about continuity of care. There are three aspects of continuity of care that we wanted to lift out here, the first one being, continuity of care to SNF services. As you're well familiar with the continuity of care policy, plans are required to provide continuity of care for all medically necessary Long-Term Care services at non-contracting, Long-Term Care facilities. And that is really to prevent disruptions in care. And of course, it's as long as certain conditions are met, and those conditions are: the facility is licensed by the California Department of Public Health, the facility meets the plan's quality standards, and the facility and the plan can agree to rates. And so, one of the things is that we would want plans to not require members that are residing in facilities that they're not contracted with, to relocate, unless that relocation is medically necessary. Because again, we want to have as minimal disruption to the extent possible. And one thing we wanted to call out specific to continuity of care for SNF services is that this continuity of care provision is automatic. What that means is the beneficiary does not have to request to stay in their facility. We would want plans to make those arrangements on the members' behalf.

Bambi Cisneros:

We'll go to the next slide, about continuity of care. So, the second aspect of continuity care has to do with providers, and there is an important difference between continuity of care for SNF services and continuity of care for providers. To stay with their providers, members must contact their managed care plan to request to keep seeing their provider. Or, it could be the member's authorized representative, or provider, that can make the request on the member's behalf. But this piece of the continuity of care policy is not automatic, so it's a kind of member-driven process. And again, similar to the previous slide about continuity of care criteria, there are certain conditions that must be met in order for continuity of care to take effect, and that is up to 12 months with their Medi-Cal provider. Those are, again, similar to the previous slide that there's an agreement to the rates, there's no quality issues with the provider, and then the other piece is that there's a preexisting relationship. So, that means that the member has seen their out-of-network primary care provider, or specialists, at least once during the 12-month period. That's how we are describing what the preexisting relationship means. One thing we wanted to note here, is that continuity of care for providers does not include providers of DME, transportation, other ancillary services, and carved-out services. So, those would not be included. This would be really for the primary care visits. And then, for dual eligible members, Medicare providers, including primary and specialty care in hospitals, do not change, and don't have to be in the plan's network. I think we can go to the next slide.

Bambi Cisneros:

The third and final aspect of continuity of care applies to other Medi-Cal services. Here we call out prescription drugs being one, and here continuity of care means allowing members to maintain their current drug therapy, which includes non-formulary drugs, without prior authorization. So, plans would not be imposing prior authorization until the plan is able to evaluate the member or reevaluate the condition. We provided a little bit of detail here on what that means, and also included the claim type is what determines financial responsibility for prescription drugs. I think you may have seen this policy through the Medi-Cal Rx policy when that was first implemented, and so, what that means is if drugs are dispensed by a pharmacy and billed on a pharmacy claim, then they are carved out and covered through Medi-Cal Rx. Then if the drugs are furnished by the Skilled Nursing Facility and they're billed on a Medi-Cal or institutional claim, then the Managed Care Plan is responsible. And so, one of the things that we also called out here on this slide is that plans may choose to cover drugs that are not covered by Medi-Cal Rx, which includes over-the-counter drugs, and other therapies that are otherwise not covered. So, nothing would preclude the plan from covering those as well.

Bambi Cisneros:

Then the other portion of the continuity of care to other services are like the bucket of all other services, and so the continuity here means it's access to those services and not necessarily the same providers. So, members would then need to switch to in-network providers for those other services that are provided by DME, transportation, both NEMT

and NMT, facility services, professional services, other ancillary and medical supplies. And of course, the plan's appropriate level of care coordination, as they determine. So, when it comes to authorizations, the policy for treatment authorizations is that the managed care plan must honor any active Fee-for-Service TARs for up to 90 days. So, whatever was existing and prior approved, they must take that into account or until the plan is able to conduct a new assessment. And then for service authorizations, prior authorization requests for members transitioning from an acute care hospital are considered expedited. So, they will require a response time of no greater than 72 hours, including weekends, and that's per standard contract requirements.

Bambi Cisneros:

For care management and care coordination, as is contractually required today, managed care plans are required to provide care coordination. This includes existing requirements around care transitions, such as discharge planning, et cetera. So, the care coordination type and level are really determined by the members' needs. But, some of the things that would include, or may include, would be: a comprehensive assessment, for example, would include what benefits, programs, or resources that member is eligible for, and the determination of that. As well as a care plan that has milestones and a plan for monitoring and following up. So, there's the standard care coordination, case management requirements that's required by contract, but then there's also other care coordination services as well. So, we would have plans then assess individual members for needs of other care coordination services, such as ECM, which is Enhanced Care Management and Community Supports, as well as Complex Care Management, which is a little bit of a higher touch than your standard care coordination case management services. I think plans know their members, and we would be looking to them to assess their needs to see what other kind of services would be needed there.

Bambi Cisneros:

So, quite a lot of policy. I know the Department and the managed care plans both have some things to do in order to really be ready for the transition and so we do have a few activities occurring here to make sure that that does happen. One of those things is the network readiness, updating member-facing materials, and data sharing. For network readiness, we would be reviewing the availability of Skilled Nursing Facilities, where they are, what's licensed and approved by CDPH or Public Health. And then working with plans on identifying those and helping to encourage some contracting relationships there. When it comes to member materials, I know Steph will talk about that a little bit later today, is managed care plan updates to their websites, to the member handbook, welcome packet, call center information, and things of that nature, to ensure they all have the same information. And when members call and inquire about the benefit, then they're able to provide that guidance and assistance there.

Bambi Cisneros:

And then finally, we have the data sharing piece. The Department has shared some

data with the plans, so plans will be receiving that data from DHCS. That is to help prepare and understand the population that's going to be transitioning to the Managed Care Plan. So, what we would expect then is that managed care plans develop processes and have those in place to make sure they share data with their downstream entities, their contracted providers. Again, for care planning and transition purposes. Here on this slide, we have a timeline of the network readiness pieces for the managed care plans. Where we are today, is working on pulling together the preliminary findings to be able to share back with the managed care plans. So, earlier in the last few months, we did share that early data, and plans were to respond by submitting their readiness template and attestation and all other documentation that was required by the Department. The team has reviewed that, and we're gearing up to be able to share back with the plans with what we're seeing. Then from that point on, in mid-October, we'll have plans resubmit their updated readiness template. We'll identify – as part of the preliminary findings that we're going to be sharing with the plans at the end of this month – we'll identify areas where we're finding to be deficient, so plans will have an ability to respond to that.

Bambi Cisneros:

A couple of months later out, so mid-December, because there are certain network readiness requirements that we are imposing, and we're working with the plans and providing technical assistance and sharing preliminary findings, we'll have the ability to impose a corrective action for plans that don't meet those readiness requirements. And also, at that time, we'll share a transitional monitoring template to the managed care plans. And this is post-transition, some of the things that we want to see from a monitoring perspective. And so, we'll be sending that out in December as well. From April 3, 2023 on, plans are then required to use that transitional monitoring template every quarter and submit the various elements that are outlined in the template there. I think we can go to the next slide. Kristin, I can turn this over to you?

Kristin Mendoza-Nguyen:

Yeah, thank you, Bambi. So we have some extra time for some questions. There's been lots in the chat. For those of you that want to ask questions verbally, please do. Under reactions, you can raise your hand and we can call on you and the team can unmute you. Just to kick us off, some of the questions in the chat that came through, "Will MCPs receive members on January 1, 2023, that are living in the LTC facilities outside of their county?"

Bambi Cisneros:

Oh, Kristin, can you say that again?

Kristin Mendoza-Nguyen:

Yeah. So, "Will MCPs receive members on January 1, 2023, that are living in LTC facilities outside of their county?"

Dana Durham:

If they're enrolled in your plan, they'll receive members who are enrolled in the plan, whether or not that facility is located in the county.

Kristin Mendoza-Nguyen:

Okay. Great. And then, “Will the January 1, 2023 enrollees only be those that choose an MCP, and February 1, 2023 will be those that are auto-assigned, or defaulted, to the MCPs?”

Stephanie Conde:

Hi, sorry, Kristin. I was trying to respond to another question in the chat. Can you read that just one more time?

Kristin Mendoza-Nguyen:

“Will the January 1, 2023 enrollees only be those that choose an MCP, and February 1, 2023 will be those that are auto-assigned, or defaulted, to the MCPs?”

Stephanie Conde:

Correct.

Kristin Mendoza-Nguyen:

Okay, great. And there was another question on share of cost. So, “Given LTC members reside in both LTC aid codes and other non-LTC aid codes, such as SPD. For LTC members with a non-LTC aid code, example, adult expansion, or SPD with a share of cost, will those members also be carved into managed care, or will it only be LTC members in LTC aid codes?”

Stephanie Conde:

Yeah, that was the question I was looking at. So, long-term share of cost aid codes are carved in. The non-LTC aid codes with a share of costs are carved out. There is a process question later on, or maybe above this that I need to run back on. So, we'll have to take the process if the member has not met their share of costs in an LTC aid code, I'm going to have to take that one back.

Kristin Mendoza-Nguyen:

Okay. Sounds good. There's a couple of questions on bed holds and leave of absences. So, there's two, “Is there a time limit to the leave of absence or bed hold?”

Dana Durham:

We'll take that back and answer that one in writing.

Bambi Cisneros:

Yeah. I was going to say, Kristin, it's really all outlined in the regulations so we can lift that up and circulate that. And actually, you know what? I think since we're working on FAQs, it would probably be good to add there as well.

Dana Durham:

Yeah, it is in the regulations, as Bambi said. I just don't know them off the top of my head. And so we're not asking anyone to exceed the regulations, but be consistent with them.

Kristin Mendoza-Nguyen:

Okay, great. All right. Let's see other questions that are coming through. And then, oh, I see a hand from Jeremy McGuire at KHS. Do you want to ask your question?

Jeremy McGuire:

Hi there. I just have a question. You mentioned the Assisted Living Waiver and the Home and Community Based Services Waiver slots. Is there a way to articulate how those separate waiver programs interact and interplay with the carve-in of Long-Term Care? Are those members who get waiver spots carved out of Managed Care Plans, or are they still our responsibility, or just curious how that works?

Bambi Cisneros:

Yeah, thanks for the question, Jeremy. They're not part of the plan benefits today. They're waiver services. And there's several of them. And so in order to be eligible for those waiver services, there's certain criteria that need to be met. And again, it varies depending on the waiver, which is one of the reasons why we're trying to move towards a statewide MLTSS in the future years, just because the benefits are so disparate across the state. But currently, today, they're separate. They're provided by waiver agencies and there's various different waivers, and they're outside of what the plans are responsible for, and they'll continue. So even after January 1, when the Long-Term Care services or Skilled Nursing Facility services are carved into managed care, those HCBS Waivers will continue to remain, but just specific to very specific target populations, criteria, et cetera. So hopefully, that answers your question.

Dana Durham:

I did see a question in the chat about whether or not an individual can be enrolled in a plan if they're not currently in the plan, but then they get enrolled in the plan in the Skilled Nursing Facilities out of the county. And what I'll say is, it's done by the county of residence. And so if that person's county of residence is within your county, then

potentially, the individual can get assigned to your plan and you would be responsible to offer continuity of care to that person and contract, or at least a single case agreement with the facility outside of your county.

Kristin Mendoza-Nguyen:

Great. Thank you, Dana. There's one question in the chat about... “Regarding urgent requests when members are currently admitted to acute hospitals, does the 72-hour timeframe start from when the request is received from accepting the SNF?”

Dana Durham:

It starts when the authorization is approved. I mean, when the authorization is submitted. So yes, I think that's right, but I just want to say that if a request for a SNF is there, then that needs to be authorized. I hope I answered that question right within the 72 hours. And Bambi, if you have anything to add to that.

Bambi Cisneros:

No, I totally agree. It's not from when it was received but when it was sent. So yeah, thanks for the detail.

Kristin Mendoza-Nguyen:

Okay, great. And the second part of that question is, “If the member is already at a higher level of care and is not at risk for loss of life, limb, et cetera, and doesn't meet the urgent definition, wouldn't the standard five business day timeframe be more appropriate?”

Dana Durham:

We believe that being in a hospital has innate risks that are there for getting sepsis and/or other types of diseases or illnesses that are hospital-based. And so, because of medical necessity, we believe that the discharge from a hospital should be seen as an urgent request. And that's where we're landing on that.

Kristin Mendoza-Nguyen:

Okay, and then one last question before we go to the next part of the presentation, “For those members receiving HCBS and AL, Assisted Living Waiver services, will the plans know who those members are? Are they still enrolled in managed care?”

Bambi Cisneros:

Because that question, Kristin, is very specific to a type of waiver, I think we'll need to take that back. So, we'll follow back up with the group on that piece. If we can capture that question, please.

Kristin Mendoza-Nguyen:

Okay, will do. All right. So that concludes that for our first Q&A session. I know there was a lot of questions, and I know we've been answering things in the chat as we've been trying to hit those as well. So with that, I will turn it over to Stephanie Conde, at DHCS, to discuss member communications and MCP data sharing.

Stephanie Conde:

Hi, good morning, everyone, Stephanie Conde with Managed Care Operations Division. Jeremy, that question about how to recognize someone in a waiver, there was a group that presented on this, on the weekly managed care plan call. There are efforts to update the data sharing on those members, so more information is forthcoming if it hasn't been sent already, but I know we presented on it a few months back. And then I'll jump right into my presentation: member communications, and data sharing. Thank you. Bringing over my notes. Okay. This timeline in the slide deck highlights an overview of key member-facing communications leading up to the SNF LTC carve-in on January 1, 2023. DHCS will release targeted notices to explain both the transition to a managed care plan, the beneficiary's options, and the continuity of care for residents. From a member perspective, they will receive two notices leading up to the transition.

Stephanie Conde:

The member notices will include a 60-day and 30-day notice along with a Notice of Additional Information, which we call it NOAI, that answers the most common questions regarding these changes. Following that, choice packets will be mailed at the end of November to beneficiaries that are not part of the Medi-Cal matching plan policy, and I'll discuss that a little bit more on the next slide. Health Care Options will conduct an outbound call campaign from December through January of 2023 to the impacted beneficiaries to help educate them on the upcoming changes. Long-term care transition specialists will be trained specifically to answer questions beneficiaries may have about the transition. In addition to these specific member outreach communications, the Department has released, and is releasing educational materials for providers, managed care plans, and ombudsman groups, just like this 101 webinar. Next slide, please.

Stephanie Conde:

As noted on the previous slide, members will receive a 60-day and 30-day notice. The version of the notice will be determined by the member population type. Given that the majority of SNF residents are duals, the member population type is largely determined if the member is part of the Medi-Cal matching plan policy. Members not part of the Medi-Cal matching plan policy will receive notices that include the name of the managed care plan the beneficiary will be enrolled in, and if they do not choose that managed care plan by the default date, that is also listed in the notice, DHCS will use an upfront provider linkage process that assigns a member to a managed care plan that works with their current long-term care facility. If their LTC facility does not work with a managed

care plan in their county, the normal default process will be used. Members that are part of the Medi-Cal matching plan policy will receive notices that include the name of the managed care plan that beneficiary will be enrolled in based on their Medicare Advantage Plan enrollment. So, the state has a Medi-Cal matching plan policy in certain counties, in 12 counties. This means that if the member joins a Medicare Advantage Plan, and there is a Medi-Cal plan that matches with that plan, they must choose that Medi-Cal plan. This policy does not change or affect their choice of a Medicare plan.

Stephanie Conde:

And then our final SNF Enrollment Notices, which the managed care plans and stakeholders have provided feedback on already, will be released in mid-September. We will post them to the DHCS website and let folks know where those are posted. Next slide, please. This table provides an overview of the DHCS data sharing with managed care plans. That first row, the first gray row. I want to note there was a question in the chat box about more education on the aid codes that are being carved in and carved out, this row represents that. In June, we did release planning level data to plans, which included a summary of the estimate based on March data. And that did include the aid codes that'll be carved into managed care. So, you should go back to your peers who may have received that from the Department, and that will list the actual aid codes, and the data to support the number of members transitioning.

Stephanie Conde:

Where we are right now is the purple row, managed care plans will be receiving CIN level data in November of 2022 to inform more on the transition planning. So this data will include utilization data and history, including TARs at the CIN level. And then this last row, the blue row, after the transition, the normal standard ongoing data feeds will continue. Next slide, please. Oh, okay. That is it for me, but I can take some questions.

Kristin Mendoza-Nguyen:

Great. Thank you, Stephanie. So the first question about some of the content you presented, “Will members where the matching is happening at the delegate level, get the matching letter or the non-matching letter?”

Stephanie Conde:

In certain counties, there is a match at the delegate level, but as per normal process, we send that enrollment transaction to your primary plan. And then the responsibility of the primary plan is to send that to the delegate. So, there are certain counties that the matching plan policy impacts at the delegate level. It's our CCI counties.

Kristin Mendoza-Nguyen:

Okay, great. And I see a hand in the participant list, California Association of Health Plans, CAHP, if you want to unmute yourself and ask your question.

Kate:

Hi, sorry. I need to change it after to a different login. This is Kate. And I heard you, Stephanie, say that you were going to post at least one notice on the website. Is that true of all of the notices that DHCS plans to send out? Just confirming, and thank you for posting any of them.

Stephanie Conde:

Sure, absolutely. Yeah. We will be posting the long-term care notices and our mandatory managed care transition notices on the website in a few weeks. Just to note, the Cal MediConnect transition notices are posted right now, and that link will be provided to the plans next week at our weekly plan call.

Kate:

Amazing. Thank you.

Kristin Mendoza-Nguyen:

Great. And then a question, “Is it possible to get the format of the data that will be shared with MCPs for transitioning members? We need this to plan for the ingestion of the members needing automatic authorizations.”

Stephanie Conde:

The format will be the same format as the June planning level data that we provide. It's very similar to your all-payer claims file that you get. So, it'll be the same data elements and the same format. So, I would check out the planning data that we provided. We did list the data elements. It'll be very similar to that.

Kristin Mendoza-Nguyen:

And then I see a hand from Sean if you want to unmute yourself from SFHP, to ask your question?

Sean:

There we go. Thank you. So I'd like to double back to a question from the chat and if you can answer now, that's great. We are desperate for an answer, anyway, at some point. Perhaps first, I'm dealing with the market realities with maintaining an acceptable network with enough beds and enough options. And the market rates – at least for skilled care – are well in excess of Medi-Cal's published rates. So, that is what it is, and is typical for niche services sometimes. But there's a concern, especially from my finance team that these excess expenses that we have to negotiate, whether in out-of-county LOAs or even in-network skilled nursing facilities, wouldn't be fully counted for purposes of rate determination. It would go a long way to reassuring us that the money

we have to spend to get placements happening is actually counted for rate determination.

Stephanie Conde:

I'm going to lean on some peers, Sean, to help with that one, if they're able to.

Rafael Davtian:

I can take this one, Steph. Hi, Sean, Rafael Davtian, Capitated Rates. So, I think your question seems to be really getting towards the managed care plan rate development process. I would suggest that we defer that conversation for a different venue. We are looking to provide additional details regarding facility payment requirements through the forthcoming APL. And then we will be scheduling a separate time with plans specifically to have a rate-focused conversation, likely, we're looking at next month. But I do want to highlight that there are statutory requirements related to the payment levels or the reimbursement that managed care plans must pay to contracted long-term care providers, long-term care facilities. So we will be addressing those within the APL in the subsequent rate-focused conversation.

Sean:

Okay. I mean, you must appreciate that whether there's a statutory requirement to pay a certain amount, there's no requirement for a facility to sign a contract at a rate that they don't agree with. So this is the tension that each plan's network manager has to negotiate.

Rafael Davtian:

No, I do appreciate the nuance and the constraint. The statutory requirement does apply to both plans and providers. Plans are required to pay and the network providers are required to accept the rate that is specified in the statute. I think it's... Again, I do appreciate the challenge you're raising or the concern that you're raising. I think it's one best addressed though in a more in-depth rate-focused conversation.

Kristin Mendoza-Nguyen:

Great. Thank you, Rafael. And thank you, Sean, for the question. So we do need to conclude this Q&A, but there will be one other opportunity. But I am excited to welcome both Stephanie and April from Health Plan of San Mateo, to talk to us a little bit about their experience with carving in these services a number of years ago. So, I'll turn it over to Stephanie and April.

April Watson:

Great. Thanks, Kristin. I appreciate it. Can everyone hear me okay?

Kristin Mendoza-Nguyen:

We can hear you great.

April Watson:

Okay, great. Thanks. Yeah, we can move to the next slide. So we just wanted to spend a couple of minutes just sharing our own experience. I'll give a little bit of historical context. As you can see the objective here on the screen, and then we'll talk a little bit about what we think has helped support this for Health Plan of San Mateo. So just by way of context and history, HPSM, Health Plan of San Mateo, we assumed responsibility for the Medi-Cal Long-Term Care benefit back in 2010. So, it's been a while. We had been working with our local SNFs, our Skilled Nursing Facilities since 2006, because we had a D-SNP. And so, we're responsible for the Medi-Cal and Medicare skilled nursing benefit. And over time, what happened in our county and in our region is that the beds available for Medi-Cal members decreased by about 10% in the last decade or so.

April Watson:

We were also pursuing other strategies like reducing unnecessary long-term care placements. We introduced a Community Care Settings program to help long-term care eligible members stay in their home. And then in 2018, we'll talk a little bit more about this in a minute, we created a long-term care collaborative to engage the local facilities in quality improvement as well as to help design an updated payment model. Next slide, please. These are the three things that we feel like have been crucial to helping support successful relationships and successfully managing this benefit. The keystones here are Skilled Nursing Facility/Long-Term Care liaison role. And that's Stephanie, who's on this call as well. And she'll be talking in just a minute. The payment changes, which I alluded to, and the Nursing Facility Collaborative. So, the Nursing Facility Collaborative and the payment changes really went hand in hand.

April Watson:

As I mentioned, we do have a quality incentives program and the guidelines for that are posted on our website. I can provide the link in the chat in just a second. But I think these three things have supported one another to help us build successful relationships and expand capacity in the long-term care facilities. So, I'm going to stop talking now and actually turn it over to Stephanie, to just talk a little bit about her role and how it impacted and changed our work with the long-term care in skilled nursing facilities. So Stephanie, over to you.

Steph Mahler:

Hi, yes. I have to say, I agree with April. These are the three key areas that we really felt that we were successful in, and that created a very strong partnership with our SNFs and LTC facilities. A little bit of my role, which is very crucial to building relationships

with your skilled nursing facilities is as a SNF/LTC liaison. I work with the hospitals. I work with the SNFs. I also work with other providers like hospice, home health. And because I'm an RN, a registered nurse by trade, it seemed to fit well that I had those provider types. So really what I do as a liaison is, I work on complex cases within the hospital and SNFs as well as building the relationships with them.

Steph Mahler:

And kind of going into some of the struggles that we did have in the past, and I won't go too much into this, but initially seven years ago, when I started, payment was an issue. "Well, Medi-Cal doesn't pay for skilled services. All we get is the per diem. We are not going to take those patients." So, something that Health Plan had wanted to do was build a payment model based on a learning collaborative. And sure enough, that learning collaborative changed everything for HPSM. And going into COVID, going into some of the challenges that we had, we found that that collaborative built such a strong relationship that we were able to work with everybody in the community, that it just worked out. Our patients were well taken care of. They were being transitioned and so forth.

Steph Mahler:

I want to stress... I want people to ask questions and I don't want to talk too much, but I have to say the best thing that... My best advice on what made us successful with our relationships with... Again, reducing lengthy stays in the hospital by transitioning to SNFs. Our SNFs are happy with our payment model. They're also very happy with the support that they get from the Health Plan of San Mateo and our Integrated Case Management model that we have. And we don't really have any issues with our community partners. I want to stress that having a liaison role that works directly with SNFs and hospitals is crucial to the relationship building and the success of that transition within the county or out of county. So I want to give people time to ask questions if there's any.

Kristin Mendoza-Nguyen:

Any questions from the group, for Stephanie or April? Feel free to use the raise hand feature and then we will unmute you. A question in the chat, “Can you speak a bit more about your Integrated Case Management model?”

Steph Mahler:

Do you want me to briefly talk about that, April?

April Watson:

Well, I'm also aware of time and I think there's more after us.

Steph Mahler:

Okay.

April Watson:

One thing we could do is we did put our contact information on the slide, and happy to have direct conversations or set up time individually with folks to answer any additional questions. I know we're running really short. So yeah, we should probably move on.

Steph Mahler:

All right. Yes.

Kristin Mendoza-Nguyen:

You guys have a couple of minutes. You're good. There's one question here, “Do you have a nurse to SNF ratio needed for the liaison role?”

Steph Mahler:

No.

April Watson:

No.

Steph Mahler:

It's just me. It's just me. Yeah.

Kristin Mendoza-Nguyen:

Okay. And does this role or Stephanie, do you live in the UM or the CM department?

Steph Mahler:

I work in actually provider services department. It's a new... This actually role was created basically for what I was doing when I was a care transitions nurse supervisor, because I used to work on care transitions in our Integrated Case Management team, but we felt that it was a provider service. That liaison with the providers, so I got bumped to provider services. Yeah.

Kristin Mendoza-Nguyen:

OK, great. Any other questions or folks that want to unmute themselves? I'm not seeing any hands. Okay.

Steph Mahler:

Yeah. And I would like to just add, I know there's lots of questions around doing this and I am free to help anybody that wants to reach out to me. I'm very well-connected, and really have a lot of pointers and can help you with building that relationship. So, feel free to give me a call or reach out to me, and we can set up some time, and talk more about it.

Kristin Mendoza-Nguyen:

Great. Well, thank you, Stephanie and April, we appreciate your guys' time today. And we look forward to hearing from more of you in the upcoming webinars as well. So that closes out our last questions facilitation. In terms of the next steps, so I know this was the first webinar in this webinar series for the SNF carve-in. There were lots of questions that came up and we will do our best to work with the Department to really make sure that you guys get clarity on those. There are upcoming webinars. They will be monthly through the end of this year, up until the early part of next year. So, please do save the dates. The information is also on the webpage that is currently going to be updated. The next couple of webinars that are listed, it is taking place the first Friday of every month around 1:00 to 2:00 PM, and the topics and the audience will vary, but it's primarily for SNFs and for MCPs. These are going to be open to the public. So, please do make sure to register in advance.

Kristin Mendoza-Nguyen:

Next slide. And lastly, I know there were lots of different policy questions and operation questions that came up. The APL is forthcoming, as well as the frequently asked questions, the FAQs. So we will most definitely take all the questions that came through the chat and that the folks that shared and we'll make sure to address those as well. If you have any other questions, please do contact info@calduals. And we'll be sure to get you guys a written response. With that, I will close this out. And Bambi, I don't know if there's anything else that you want to say to close us out.

Bambi Cisneros:

No, nothing, except just thank you for your time. And I think we'll continue to have additional time and dialogue on this topic just to make sure everyone's all on the same page and has all the same information. So, thanks again for your participation, and we'll talk more soon.

Kristin Mendoza-Nguyen:

Great. Thank you, everybody. Have a good day.