



MICHELLE BAASS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

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

TITLE: CalAIM Community Supports Spotlight: Nursing Facility

Transition/Diversion to Assisted Living Facilities and Community Transition

Services/Nursing Facility Transition to a Home

DATE: Thursday, September 15, 2022, 12:00 PM to 1:30 PM

NUMBER OF SPEAKERS: 8

FILE DURATION: 1 hour and 29 minutes

SPEAKERS

Jill Donnelly
Neha Shergill
Anastasia Dodson
Jorge Medina
Jeannine Nash
Danielle Vincer
Nicole Bell
Yousaf Farook

Jill Donnelly:

Hello, everyone. I'd like to welcome you to our fifth CalAIM Community Support Spotlight webinar. We're going to give folks another moment or two to join and then we'll get started.

(Silence).

All right, why don't we get started? I know some folks are still joining. Welcome again. My name is Jill Donnelly. Before we begin, I did want to run through a few housekeeping notes. So, all participants will be on mute during this presentation, we'll have some time reserved for questions at the end of the webinar. Please submit any questions you have for the presenters via the Q&A feature on Zoom, which you'll see in the center bottom of your screen. We ask that all of the questions be submitted that way and not through the chat. The PowerPoint slides you'll see today and all of the meeting materials will soon be available through the DHCS website. We will share some details on where to access that information in the chat, and a recording of the webinar will be available shortly as well. We do have closed captioning for this webinar. If you'd like to use this, click on the closed captioning at the bottom of your screen and select subtitles.

And we can go to the next slide. Great. So, with Enhanced Care Management and Community Supports now being launched statewide, MCPs and ECM Community Supports providers are utilizing the DHCS issued standardized data exchange guidance to operationalize the program. Just today, the department released a required survey for all MCPs and their launched ECM and Community Supports providers. The hope here is to better understand the status of data transactions between organizations, where the data exchange barriers may be, and where they may benefit from expanded or refined guidance.

So the survey is an opportunity for stakeholders to provide feedback on early implementation and to provide input for DHCS to ensure long term adoption and success of the benefit and Community Supports. There is a link here and we will put it in the chat as well, it also went out through email this morning to MCPs and providers via a SurveyMonkey link. This will be open through October 7th, and we do ask that only one survey submission per organization be submitted. More information can be found on the ECM and Community Supports DHCS website, or by reaching out to the shared mailbox. And we do have links here at the bottom. Again, we'll throw some of these in the chat as well so they're easy to grab. So, fill out your surveys.

All right, next slide. So I'm going to hand this off in just a moment, but just to restate, today is one of our Community Supports Spotlight Webinars. We're going to be talking about two really exciting Community Supports, the nursing facility transition and diversion to assisted living, facilities and the community transition services and nursing facility transition to home. So we are going to do a little bit of overview upfront, hear from some really wonderful presenters, and then hear from the field and how it's going in practice. We'll also have a Q&A at the end, so stay tuned for that. And with that, I will turn things over to Neha from DHCS to introduce CalAIM and Community Supports.

Neha Shergill:

Thanks, Jill. So we'll begin with a brief overview of CalAIM Community Supports. Community Supports are medically appropriate, cost-effective alternatives to services. Medi-Cal managed care plans may provide in lieu of services, traditionally covered by Medicaid. So Community Support services are designed to potentially decrease utilization of other Medi-Cal benefits, 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 Community Supports. CalAIM currently includes a robust menu of 14 pre-approved Community Supports to address the health needs of members. The list of pre-approved Community Supports is informed by the work and lessons learned under the whole person care pilot and the health homes program. Managed care plans selected Community Supports to offer when CalAIM went live on January 1st of 2022, and have the option to add new Community Supports every six months. Managed care plans in all counties are encouraged to offer at least one Community Support by January 1st of 2024.

Next slide please. So the Community Supports are in lieu of services, which are medically appropriate and cost effective services or settings offered by managed care plan as a substitute for a Medicaid state plan covered service or setting. Under regulatory requirements, in lieu of services must be authorized and identified by plan contracts and offered at plan and enrollee options. This really allows for Community Supports to cover a broad range of social and support services for eligible populations. These are financed through capitated rates to plans in the same way as state plan services and do not require 1115 waiver settings.

So this slide outlines, the 14 pre-approved Community Supports that we have, and today's webinar is intended to provide information about the nursing facility transition and diversion to assisted living facilities and community transition services, and nursing facility transition to a home, supports and help inform you as you consider offering these supports to plan members and patients.

Next slide please. So at this time, 77 plans by county have elected to offer both the nursing facility transition and diversion and community transition services Community Supports by January of 2024. By that time, both supports will be covered by 16 plans across 38 counties in the state.

So together, the nursing facility transition and diversion to assisted living and community transition Community Supports are part of the department's plan to build infrastructure over time, to provide managed care, long-term care supports statewide in order to meet the needs of aging beneficiaries and individuals at risk for institutionalization. The supports highlighted today are part of the nursing facility transition and diversion, and ongoing supports for community living, which also includes personal care and homemaker services and respite services for caregivers. And with that, I'll hand it over to Anastasia Dodson from DHCS, who will take us through the guidance on nursing facility transition and diversion to assisted living facilities.

Anastasia Dodson:

Wonderful. Thank you so much, Neha. I'm just very proud of the work that we're doing here at DHCS and the team that we've assembled, as well as all of you partners on the line here today. And it's just such an exciting time for the department. And particularly these particular Community Supports are a long time coming and they build on work that the department has done in the past, but are really forward-looking.

And so anyway, with that, we'll go to the next slide and we're going to talk about a summary of the guidance on the nursing facility transition and diversion to assisted living. So what are these Community Supports? They're... Just starting with some basics, the Nursing Facility Transition and Diversion Services Assist individuals to live in the community and/or avoid institutionalization when possible. The goal of the support is to both facilitate nursing facility transition back into a home-like community setting, and/or prevent a skilled nursing facility admission for members with an imminent need for nursing facility level of care.

These types of supports provide eligible individuals the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. Nationally, states have been exploring upstream strategies like these to help patients avoid nursing home placement in what are known as nursing home diversion programs, and downstream strategies to help nursing home residents return home with support in what is known as nursing home transition.

So again, states, including California, have been working on these strategies, but we have them now assembled in such a way that hopefully it can really be accessible to as many people who can utilize them as possible.

All right, next slide. So how does nursing facility transition and diversion to assisted living facility work? So with this support, the assisted living provider is responsible for meeting the needs of the member, including activities of daily living known as ADLs or instrumental ADLs, meals, transportation and medication administration as needed. This service is for individuals who are transitioning from a licensed healthcare facility to a living arrangement in a residential care facility for the elderly or adult residential facilities. This support includes wraparound services like assistance with ADLs and IADLs as needed,

companion services, medication oversight, and therapeutic social and recreational programming, provided in a home-like environment. It also includes 24-hour direct care staff on site to meet unpredictable needs in a way that promotes maximum dignity and independence while providing supervision, safety, and security.

All right, next slide. So this is a little bit more, we're looking a little bit deeper, so more closely at the service offerings that are provided. There are allowable expenses for nursing facility transition and diversion services are those that are necessary to enable a person to establish a community facility residence, except for room and board, but that do include and are not limited to assessing the member's housing needs and presenting options, assessing the service needs of the member to determine if the member needs enhanced onsite services at the RCFE or adult residential facility, so the member can be safely and stably housed in these facilities.

Also, assisting in securing a facility residence, including the completion of facility applications and securing required documentation, such as a social security card, birth certificate, prior rental history. Communicating with the facility administration and coordinating the move, establishing procedures and contacts to help the members retain that facility housing, coordinating with the Medi-Cal managed care plan to ensure that the needs of members who... If they need enhanced services to be safely and stably housed in an RCFE or adult residential facility setting, that they have the Community Supports or enhanced care management services that provide the necessary enhanced services. And managed care plans may also fund our CFE or adult residential facility operators directly to provide these enhanced services.

So again, this is really a wonderful watermark for all of us here in California. We know that housing is one of the key issues that many people struggle with, and this is a way to assemble. And we're going to talk about some of the... There are also some caveats here with how payments for direct housing services may not be necessarily included here, but all of the supports that are needed can be assembled and coordinated here.

So next slide. So note that nursing facility transition and diversion Community Supports covers ongoing expenses for members receiving it in an assisted living facility, so it's not necessarily just one time. And for individuals who transitioned from a nursing facility to home, the Medi-Cal plans may elect to offer the personal care or homemaker Community Supports to support the ongoing ADLs and IADLs.

All right, next slide. So we just also want to note some benefits and outcomes associated with nursing facility transition services that are piloted across the country. So a Minnesota nursing facility transition program targeting Medicare recipients who had been in nursing facilities for 60 days or more, found that 50% of individuals who have been placed in the community continue to live in the community after one year. A diversion and transition continuum program for Medicaid members living in nursing homes in Connecticut promoted transitions from nursing facilities and diversion from long-term institutional care. And that program achieved a 14% increase in discharges from skilled nursing facilities to home within six months of admission, from 27% to 41%. And finally, among states with mature nursing facility transition programs, roughly 25% to 35% of residents who relocate from nursing facilities, transition to assisted living facilities. Lots of interesting data and really good evidence there.

Next slide. Okay, so as far as the eligibility criteria for this community support. For nursing facility transition, the member must have resided for 60 or more days in a nursing facility, be willing to live in an assisted living setting as an alternative to a nursing facility, and finally, be able to reside safely in an assisted living facility with appropriate and cost effective supports. For nursing facility diversion, the member must be interested in remaining in the community, be willing and able to reside safely in an assisted living facility with appropriate and cost effective supports and services, and be currently receiving medically necessary nursing facility level of care, or meet the minimum criteria to receive nursing facility level of care services. And in lieu of going into facility, is choosing to remain in the community and continue to receive medically necessary nursing facility level of care services at an assisted living facility.

So some of these are technical, but it does build on some of the definitions that have already been used in

this area, in these types of programs. So some of you are probably very much experts in this, and some of you are just learning about it. But again, we're assembling pieces that are not necessarily brand new, but assembling them in a new way with deepening those partnerships between Medi-Cal plans and all of you, all the partners and you know how to make this work. So hopefully we're giving you the right tools here, and this can be successful. And the more and more partners plans, areas of the state can learn and grow this opportunity.

All right, next slide. So this is about allowable providers. So the providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner, of course. California is an extremely diverse state and we need to make sure that, to be successful, the program needs to meet people where they are. And again, culturally, linguistically appropriate is essential.

There's other items on the list as examples of the types of providers that Medi-Cal managed care plans can choose to contract with, but it's not an exhaustive list of the providers who can offer these services. So case management agencies, home health agencies, Medi-Cal managed care plans, adult residential facilities, and residential care facilities for the elderly, operators of those types of facilities. Those are all allowable providers.

Okay. Next slide. So there are some limitations again. So just key note that individuals are directly responsible for paying their own living expenses. As with all Community Supports, this services, supplements... This service supplements and does not supplant services received through other state, local or federally funded programs. Medi-Cal is a payer of last resort. So with that, I'm going to hand it over to Joseph Billingsley, assistant deputy director at DHCS, who's going to take us through the guidance on the next community support. Thank you.

Jill Donnelly:

Thank you, Anastasia. And I think we actually don't have Joseph for the moment, so I'll get us started on here. And if he joins us, I'm happy to hand it over. So we're going to move on now to talk about community transition services and nursing facility transition to home. They're a non-recurring setup expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence, where the person is directly responsible for their own living expenses, as Anastasia just discussed. The community transition and nursing facility transition to home helps individuals to live in the community and avoid further institutionalization.

So what are some of these community transition services? There are a lot of them out there. They could include assessing a member's housing need, presenting them different options, assisting and searching for and securing housing, including the completion of housing applications, securing required documentation like a social security card or a birth certificate, that kind of thing. Communicating with a landlord if that's needed, and helping to really coordinate that move, establishing procedures and contacts to retain housing. Identifying, coordinating, securing and funding non-emergency, non-medical transportation to assist that member's mobility, ensure reasonable accommodations and access to housing options prior to transition and then again on move in day. And identifying the need for, and coordinating funding for environmental modifications, if there are accessibility modifications that are needed.

Next slide under community transition covered services, these include things like security deposits required to obtain a lease for an apartment or a house, setup fees for utilities or service access, first month's coverage for utilities, phone, electricity, heating, water, that kind of thing. Services necessary for the individual's health and safety, that could include pest eradication and one time cleaning prior to occupancy. Home modifications such as an air conditioner or heater, and then other medically necessary services, if they need a hospital bed or a lift, other things like that to ensure access and reasonable accommodations.

Next slide. So let's talk about who's eligible? The population eligible for this community support include those who are currently receiving medically necessary nursing facility level of care services. And in lieu of

remaining in the nursing facility or a medical respite setting, they choose to transition home and continue to receive medically necessary nursing facility level of care services. They have to have lived 60 plus days in a nursing home or in a medical respite setting. They have an interest in moving back to the community, back to their home, and they are able to reside safely in the community with appropriate and cost effective supports and services.

Next slide. All right, allowable providers, as Anastasia mentioned, this is... We have a list-

Jill Donnelly:

Providers, as Anastasia mentioned, we have a list here of some common types of organizations that may choose to offer, but this is not a limited list. So, other folks who may be interested in participating may be eligible. Common types of providers include case management agencies, home health, managed care plans, county mental health providers, 1915c HCBA/ALW providers, and then CCT/Money follows the person providers. Next slide.

This is another one with some really interesting data supporting the effectiveness of the program. We've got a couple statistics listed here. I believe someone in the Q&A asked for citations, which we are really happy to share. But in various studies, care transitions were associated with the decrease in 12-month readmission rates, from 17% to 12%, a 20% increase in global life satisfaction among individuals who transition to community living, and care transitions producing a savings of up to 50%. Again, a lot more detail on the citations and more nuances of those data points are available through links we will share. We can go to the next slide.

A couple limitations and restrictions. Community transition services do not include monthly rental or mortgage expenses. They don't include food, or regular utility charges, or any household appliances, or items intended purely for diversionary or recreational purposes. They're payable up to a total lifetime maximum of \$7,500. There is an exception to this, which is listed here. If the member is compelled to move from a provider-operated living arrangement to a private residence through circumstances beyond their control, there could be an exception to that. They must be necessary to ensure the health, welfare, and safety of the member. Again, if the member would not be able to move to a private residence without these, that's the threshold the state is looking at. And just like nursing facility transition and diversion, the support should supplement and not supplant services received through other state, local, and federally funded programs.

We're not going to get into the weeds on pricing right now. But there is a really useful document that we've linked here available through the DHCS website that lists non-binding ILOS Community Supports pricing guidance, on a high level, for typical staffing ratios and service intensity. So, more information through that link.

All right, we are really excited now to move away from talking about the guidance and talk to folks in the field about how this is going in practice. I'd like to introduce Jeannine Nash, the Director of Operations for Serene Health, and Jorge Medina, Director of Business Development, to talk about nursing facility transition and community transition. I'll hand it off now to Jeannine and Jorge.

Jorge Medina:

Thank you, Jill. Hello, my name is Jorge Medina. I am the Director of Community Development for Community Support for Serene Health. And I have Jeannine Nash here as well. She's the Director of Business Development for our community support, or I'm sorry, of operations for our community support services. Thank you to DHCS and Kathleen's team for everything you do in putting these webinars. I know there's a lot that goes on behind the scenes in organizing this, and they're always so informative, and we are very happy to be here. Also, thank you to all the MCPs, the providing partners, and everyone involved, the lead care managers. We're very big on one person can make a difference, but it's when you have a big group like this that can make the change and be the change that we're looking when we're all working towards one common goal. And so, we wanted to talk about our best practices that we use that help us be

successful in the nursing facility transition and community transition services. Next slide.

We are a positive choice. We are this CS department for Serene Health. Our mission is to assist our members with obtaining the resources and referrals necessary to live an independent lifestyle within their community with respect, integrity, and dignity, making a difference within our communities to help one person at a time and changing their lives. Next slide.

We are based out of San Diego, California. We provide community support services for over 22 counties in California and are growing. We have been in the community since 2014. We, actually, here on the map, we have all our different offices. Not shown is two other offices that we are actually opening up in Mendocino County and Solano County, and are looking to continue to grow to continue to provide support and resources for some of these other surrounding counties as well. Next slide.

Populations of focus. As you know, 2022 was mainly focused on individuals and families experience homelessness, high utilizers, adults with serious mental illness, substance use disorder adults and children, youth transitioning from incarceration. And with 2023 just a few months away, that opens up for adults at risk for institutionalization who are eligible for long-term care services, nursing facility residents who want to transition into the community, and then children or youth up to 21. Next slide please.

Some of the best practices that help us be so successful is planning. Having a comprehensive discharge plan is huge and key. Organizing the follow-up services, addressing any kind of financial barriers, psychological barriers is very important when we are assessing the member in what we're planning, and trying to do, and accomplish in this transition or diversion, which again, assessing those financial barriers to filling the member needs of long-term care goals. So, we make sure that we assess their financial resources, we plan if they are deficient in a certain aspect of those resources that they need or financially. We like to see what else is out there to make sure we work together with them, so that way when we do transition that member they are successful and they are able to continue on independently.

Collaborating is very critical as well, not only with the outpatient providers and any case managers, making sure again, any providers that we're working with have any test diagnoses, caregiver statuses, making sure that all the services that are needed for this person to be successful are coordinated across all boards. Sometimes we're not just reaching out to the individual, we're reaching out to their family, the provider, the caretaker as well, depending on the member's situation. So, that collaboration is always very crucial and making sure that communication is there.

Another component of that as well is patient understanding. We like to utilize the teach back method where we go over the goals and the plan for the member, but we also have them repeat it to us so that way they understand and have an understanding of what is going to be required, what our next steps are. If we need to illustrate, or have a flow chart, or a weekly chart as well, we'll accommodate to whatever that situation is or whatever's the simplest way for a member to understand, so that way they are 100% in tune with what we are doing and the whole discharge plan that we're creating for that particular member. Next slide please.

And then again, open communication. Continual communication is also very key to provide that high level of care. So, just making sure responsibilities across anyone involved in this discharge plan are defined. If we have to create an organization chart or a follow-through chart on different things, what medication, where we're going to get certain services, transport, we'll do that as well to just ensure, again, that everyone's on the same page when we are working towards this discharge plan goal. And then also, a big piece of it is also a prompt followup visit with the outpatient community provider after discharge, so we can check in on the member, making sure that they're comfortable. We typically do this within the first seven days of discharge, because those to us are the most crucial, is getting them comfortable, getting them settled. If we have to be on the phone with them for the next seven days and then visit within those seven days, we'll do that as well, just to make sure that they're comfortable, they feel secure, they are transitioning easily into their new respective home, and ensuring that they have a successful long-term transition.

One of the reasons we are able to be so successful is we actually also utilize a custom platform that's

designed for ECM and CS services. So, within that platform, we're able to communicate, set up appointments, have followup reminders and things like that to help us facilitate these transitions and changes for these member care plans or goals as we adjust in real time. And research strongly suggests that these best practices create a real strong foundation for high quality, cost saving, care transition. So, just if anything, that communication is the most crucial, making sure we're communicating across everyone involved with this transition or diversion.

And then, next slide please. I will actually kick this off to our director of operations, Jeannine Nash, to touch on the referral process.

Jeannine Nash:

Hi, everyone. My name is Jeannine Nash. I'm the director of operations with Serene Health Community Support Services. Just to let you know, the referral process, you can submit any referrals either via email or via fax. Once we receive that referral, we'll reach out to the member to opt the member into services and get them to have them. Once they accept services, we move into the submitting the request form to the health plan. We utilize the health plan's authorization request form. Once we get authorization back, then we're able to move the member into the intake process of community support intake where that will begin. So, that process will begin by assigning the member to an LCM. That LCM will complete a IHSP, which is a individual housing support plan, and then also create an action plan.

That action plan and the IHSP will set them up with an assessment. That assessment process will start the placement process where we're able to reach out to different resources in order to at least offer the member at least three choices of an RCFE. The assessment process also gives us the ability to say which direction and which type of RCFE to refer the member to. We give the member the option of doing tours. They can either do a tour in person or we can bring videos or we can bring pictures as well for the member. We will assist the member with paperwork, so all the paperwork can get done in order for the member to move into their next best place to call home. And we will also assist the member with arranging for movers and also assist with getting the room ready. It's important for the member to walk into a room that's full of their own belonging so they can feel at home.

We also assist the member on the day of move in. So, the day of moving, we're there with the member to introduce the member to all staff, including from the receptionist to the executive director. We want to make sure that they meet the med nurse as well, the chef who's going to be preparing their meals, also the laundry attendant, and also activities director, so they know that they can still have that social life. It's important to walk the member into their next place to call home. And at the same time, the LCM will continue to do calls, weekly calls, and also do in-person visits to make sure that they're feeling comfortable.

If a member is actually going from nursing home to back to their own home that is not an assisted living, then we make sure that they are covered with a personal care attendant. And that personal care attendant has the ability to assist them with all of their personal care needs in the home, all the way from helping them with laundry, housekeeping, ensuring that they're taking their medications on time, ensuring they're getting back and forth to their doctor's appointments, so they can continue to live a successful life. Next slide.

Just to give you a little idea about a successful placement that we had. We received a letter from one of our members, and the letter states, "Thank you, thank you, thank you, thank you, thank you, thank you. If this is a heaven on earth, we found it. Linen tablecloths and beautiful clean silverware, a real menu. We can order two meals a day. I ate shrimp for lunch and dinner. The first day, I had all the ice cream I wanted. My eyes no longer burn." Sorry, I get emotional. "My eyes no longer burn. My face has healed, and I can breathe. I sleep solid every night or until the sun comes up from the east and blinds me.

Today, I went into the shuttle with other residents to Walmart, four miles. When we came back, there was grocery bags and people everywhere. I stumbled on the yellow dots, the speed bumps in front of Walmart. Luckily, I was holding onto the basket. I sprained my right ankle. But if you're having fun, the pain isn't that

bad. Wednesday, I have an appointment at the Beauty shop to get my hair cut. I don't have to cut and style my hair ever again. And I just sit in the walk-in shower and it feels so good, so clean. After five months, my feet are clean. Some of the ladies are pointing out the single guys, retired officers, and money, et cetera. But I'm not ready for that. I'm so excited to be in heaven on earth. Thank you." And so, that's our community support services.

Jill Donnelly:

Thank you so much Jeannine and Jorge. We really appreciate you sharing so much about how things are working for you and also for that really lovely letter at the end. I really appreciate it. All right, we're going to now move things to our next presenter. I'd like to introduce Danielle Vincer who's the Vice President of Community Living Services from the Institute on Aging. Danielle.

Danielle Vincer:

Thank you, Jill. Good afternoon everyone. I was a little scared having another presenter providing best practices right before me, but we have some different ones, so we're not going to be just overlapping. But there was a very consistent message that communication is key. So, you'll hear that in my points as well. As Jill mentioned, I'm Danielle Vincer, Vice President of Community Living Services at Institute on Aging. You'll hear me refer to Institute on Aging as IOA, just FYI. I'm a registered nurse. I've been in case management since 2010 in the acute care, post-acute, and community-based world, as well as I have my master's in healthcare innovation. Next slide.

To give you a little bit of information about IOA, care management is the world that I work in, but IOA does a lot more than just that, primarily in the Bay Area. We have four key priority impact areas focusing on dementia, caregiving, social isolation, and loneliness, and alternatives to long-term care. Now today, when we're talking about the Community Supports for the skilled nursing facility transitions and diversions, we're talking about the community living solutions area. But as we're talking about personal care services and respite services, that will be touching on some of our key other priority impact areas as we move forward. But today we'll just focus on nursing facility transitions. Next slide.

IOA has been doing intensive care management for quite some time. Back in 2007, we launched our Community Living Fund in San Francisco along with the Department of Disability and Aging Services. I would imagine most of you have probably heard of Laguna Honda Hospital by now. In 2007, our Community Living Fund program focused on transitioning individuals out of Laguna Honda into alternative housing options, such as RCFEs or independent housing. Seven years later, we launched our Community Care Settings program in San Mateo County, along with Health Plan of San Mateo and with the Whole Person Care pilot. And in 2017, we launched our Whole Person Care program in Santa Clara. So, today, the San Mateo program and the Santa Clara program have both transitioned to be part of CalAIM. All three of these programs provided transition and diversion services with the main focus of enabling individuals to maintain their independence in the community. But today, today we'll talk about how San Mateo and Santa Clara have moved forward. Next slide.

Well, as far as the enhanced care management and Community Supports, we offer a number of different populations of focus as well as community support services in our various counties. I did add nursing facility transitions to the population of focus. Maybe it's more wishful thinking or excitement for January. But we have been working with those other populations up to now, and then also offering the nursing facility transition and diversion Community Supports, which I will speak to our best practices and what's working for those.

Okay, so through our years of care management and transition services, we learned a lot of important lessons. Then we had to move our programs into the CalAIM world, which forced us to challenge what has worked, how do we maintain our ultimate focus on patient-centered care while staying within the restraints of the CalAIM policy guidelines. But it's been a really beautiful combination of services with the enhanced care management and Community Supports.

What we found, and this isn't just specific to nursing facility transitions, because that population of focus is yet to go live, but in general, when it comes to individuals who have enhanced care management and Community Supports, we have found that streamlining providers when possible is a best practice. As we know that clients, or we call them clients or patients, when they're going through some of these life changing experiences, it's confusing, it's scary. There's a lot of people that are involved in their care, and reducing the number of care managers that are assisting them, we have felt has helped them with the process so that they don't get confused.

Additionally, there can be duplication in work between enhanced care management and Community Supports. There is some gray areas, what falls as a care management on one side of the line or the other. And so, streamlining and having one individual doing that work can help with reducing duplication, as well as things falling through the cracks. If there's too many cooks in the kitchen, things can get missed. Obviously, communication is a key to that not happening. But again, with one provider that helps.

If it's not possible to have one provider, that collaboration is key. That critical communication between providers will be important. But if there is one service that's provided, let's say somebody has a community support authorization and they don't have enhanced care management, what we have found is it is a best practice, if they qualify, to request that enhanced care management authorization as well, because they may be eligible for more services, but that authorization just isn't in place. So, that's the second part of that is requesting additional authorizations.

Second piece is the waivers. Once a client is authorized for Community Supports, it's important to start that waiver application process as soon as possible. A large.

Danielle Vincer:

To start that waiver application process system as possible. A large portion of these individuals are going to be eligible for the California Community Transitions. Waiver, or CCT, or AKA Money Follows the Person, or the ALW, the Assisted Living Waiver program. Both of these programs can take some time for the application to be processed and everything to go through. And so, starting it immediately is important, especially for these RCFE transitions because the ALW offers a sustainability plan for these folks. It has a tier that will help to ensure that their adequate care needs are being met based on their tier levels, which as well identifies a reimbursement amount for the facility. So, those waivers are really important to get going immediately.

The last point I want to make is about RCFE options. The previous presenter was talking about offering three different facilities. Options are important. And in order to have a successful placement, you have to take everything into consideration. The behavioral health needs, can they handle dementia? What competencies do they have when it comes to the cultural competence, clinical, behavioral, geographical specifications? So, in order to provide enough variability in the options, what we've done is we have an outreach coordinator whose actual role is developing the RCFE network. They go out in the community and work with the administrators, and sign facilities up to be part of our network so that we have options for our clients or for the members. And they also can assist with the Assisted Living Waiver provider process, helping them to understand how they can be an ALW provider as well.

Next slide.

Okay. So these may not be... They may be best practices, maybe not, but we've found that at least these things are working for us. Historically, we have found that we have achieved a lot of success with a multidisciplinary team approach. Our [inaudible 00:48:08] teams have an occupational therapist on the team. We have a registered nurse who is available for consults for clinical needs, as well as signing off on the ALW and the CCT applications. We have the licensed clinical social workers, masters level social workers. And community health workers.

We've also developed tools for the multidisciplinary team to use. One in particular, we have a discharge checklist, and it really speaks to those wraparound services. And some of those practices that Jorge was seeing needed to be done in advance for a successful transition. Arranging DME, transportation, PCP

follow-up, all that stuff. And we have a centralized way to be able to manage those tasks so that we can ensure that everything is in place prior to transition to ensure a more safe and successful move.

The second point I want to make is about specialized Community Supports care managers. We're offering a lot of different care management services between the ECM and Community Supports. And we found it's important to align the skills and experiences of the care managers with the client complexity and their acuity needs. Transitioning out of a skilled nursing facility is complex. I mean, they're going from a place, a facility where they have 24/7 medical oversight, there is inpatient clinicians on staff, and now they're going to an RCFE where they have caregivers, but they don't have as much medical involvement. And so, making sure that you have a really safe, and secure, and solid plan is really, really important.

And so, what we do is we have dedicated care managers who manage the transitions. We have different care managers who can manage the housing navigation services or other Community Supports. But for the transitions in specifically, we need to make sure that we have experts, that they know the process, they know what red flags to look out for, and they know when to follow the green light. So we have our dedicated transitions care managers here.

The last point is the claims... We were just told Jill was talking about a survey that's going out. The claims, reporting, and authorizations process is tricky. We've found that there's variability. There is complexity. Every plan has asked for a little something different. Different regions have different requirements. Starting these up and customizing it, it's been challenging to develop to scale. We've built out a electronic health record system to be able to manage this, but again, everybody is doing this a little bit differently.

So, one solution that we've found is we do have a dedicated claims ops and reporting team. This is for Community Supports and ECM. It's, really, for all of our accounting activities. But in order to capture all the specifications and the encounters, create the 837P claims, deliver the proper reports that are needed, we found that we have to have a dedicated expert to develop and manage those ongoing execution of requirements so that they can support the operational team as we move forward.

I hope you find these points helpful. And thank you for giving me this time, DHCS and providers. And thanks for letting me talk about IOA. And also, happy Mexico Independence Day, everyone.

Jill Donnelly:

Thank you so much, Danielle. All right. So we've heard a couple really helpful provider perspectives. We're now going to hear from a health plan. We're so happy to have Nicole Bell, a Community Supports program manager at Santa Clara Family Health Plan to come and speak with us. So, Nicole, will hand things over to you.

Nicole Bell:

Hi, thank you. I'm Nicole. I'm the community-based program manager, and I work for Santa Clara Family Health Plan. Santa Clara Family Health Plan is the local community-based health plan that was created to really... It is really trying to create opportunities for health. We are a public agency, and we are accountable for many of our community members. We started our program... Our company started in 1997. And right now, we have a little bit over 280,000 members. And then, right now, we have a Medi-Cal plan, and then a Cal MediConnect plan. And we plan to also launch a decent option in January next year.

Next slide, please.

Our mission is to improve the wellbeing of our members by addressing their health and social needs in a culturally competent manner. And really partnering with providers and other organizations that share the commitment. And our vision truly is health for all, and really wanting to make sure everyone in the community has opportunities for health.

Next slide.

These are the 14 Community Supports that we are all familiar with. The top ones are ones that we have already provided or we've already launched. We are planning to launch a couple more in January. And

then, finally, the last two in July of 2023.

Next slide.

So, why did we decide to offer nursing home facility transitions or navigations as a community support? We actually decided this because we have some expertise in this arena. We've been part of the Coordinated Care Initiative, or CCI, since 2014. And we have a large CBO network that are very experienced in this kind of population. And then we have a pretty close collaborating relationship with the County Continuum of Care, or CoC. And so, we really thought that this would be the best option to launch. This is one of the first options we launched in January of last year.

Next slide.

So, to go into a little bit more detail, we really focus on partnerships. And we have best practices that we've already set up. And we really feel that they've worked really well for us, and we try and be really good partners. So we have a network of... Through the Coordinated Care Initiative, we have established a network of over 40 skilled nursing facilities. We have a designated provider service person who actually only works within nursing homes. And they are able to really collaborate and work closely.

We have an infrastructure already that was starting to be developed, but it had the very basis, very good foundations, which really looked at cross-functional teams within the health plan and also outside partners. And then, we have identified specific common characteristics for what an appropriate discharge or a member that would be best fit in the community versus in the long-term care setting. And then we have a designated case manager that really is there to coordinate all of those discharges.

And then, finally, we partnered with the subject matter experts in the county, and we worked with many of the services and providers that had already been established in the community and had already been working with these members. So we followed or we reached out to, and we partnered with Silicon Valley Independent Living Center and Institute on Aging, IOA, is also one of the partners that we really collaborated with to get the starting point of our program.

Next slide.

How do we start? Basically, we started with a program development, and we looked a model, or changed the program development into a program model. We did a outlined, a high level, what you should do based off of the guidance that was provided by DHCS. And then, we got input from our community providers. We got input on things like what services they needed to be providing, how much it would cost, what kind of clinical level of care, that kind of thing. And then we finalized those service bundles, or what we call service bundles. We finalized the models. And we then send them out again. And we make sure that all of the community-based agencies were really able to understand what we were trying to get at, basically.

Next slide.

This is our finalized program model. We really looked at segmenting out each one of the different types of services. And we put timeframes, excuse me, in place so that the community-based organizations could actually build prior to completing the full communities part.

Next slide.

We really focused on some of the pricing assumptions. We split things up into different levels, and we created a lot of follow up, and had engagement meetings, and talked about different salaries. I mean, there was just so many different ways of looking at how we could parcel out each one of the services. And we took all of the feedback into consideration.

Next slide.

Once we finalized all of the program models, we also decided to really look at the provider network and make sure that we had an adequate network. We partnered with local agencies, and we did a local landscape assessment of all of the providers that could potentially assist us in this community support. And then we compared all of their experience. We looked at who is going to be best fit for these kind of

transitions. And then we drafted and sent out our readiness assessment, and really have all of the providers able to provide us enough information that we felt that they had the correct staffing, they had the program, the skill sets, and that they had the linkage to getting the members out. We ended up contracting with 13 providers. And we've had, I think, 15 placements so far.

Next slide.

And this is just a little bit more about the provider engagement. We did really try and align with the populations of focus, and really collaborate with ECM providers and our ECM team so that we can make sure that everybody understands what is being offered and how a member could be qualify. And we are doing ongoing training. We have deep dive series that really looks at how Community Supports and ECM overlap and give very detailed information or examples and provide the additional information with the program models.

Next slide.

So, the impact, really, with the program models and the provider network is just that we wanted to make sure that everyone was able to... We were able to compare each one of our providers, and that they all had the same amount of... They were all doing things rather pretty much the same. And that's why the service bundles worked. We have a way of comparing it. And we also reflected that each of... It reflected that all of the populations of focus and all of that work we had already done was linking in.

Next slide.

We've also done a lot of community in education. We've developed a program user guide. And we have material that we can send out to members.

Next slide.

And then, really, the outcomes were, we have one. We've contracted with one provider that really has a very strong expertise and experience with RCFEs. And then we have three other providers that are able to do the nursing home to home transitions or the diversion to home transitions. Right now, we have 12 members, 12 members that are in our RCFE-enhanced care services, which is the continued care while the members in RCFE. And we are working on identifying how much RCFE capacity. We have a cap of 15 members for right now, but then we're definitely looking at this RCFE development. And we utilized funds through our IPP funding. And we are working with IOA to do that as well. And we will have... We're also promoting the ALW program and alignment.

Next slide.

The biggest lessons learned is just that we... Sorry. We really thought that it's really important to have really strong workflows, discuss how to provide the services, make sure everybody understands the different models, and make sure that there's not any miscommunications. As Danielle has said, communication is definitely a very important thing in this kind of situations. And then, data sharing, we want to make sure that all referring parties and accepting parties know that we need to have appropriate information in order to even approve these services. So there was a lot of ongoing training, or there's a lot of ongoing training, and then there's a lack of housing in the county. And so, we really, really wanted to make sure that that is something that we can address. And so, we've now joined the CoC, and we're really helping with that promotion of support of really investing in the permanent supportive housing. And we're looking at alternative housing options, things of that nature.

And then, finally, the really to determine how we could fit into that RCFE role and look at how we can maybe address some of the high costs that come in to play with RCFE in general. And that's actually why we end up paying a higher rate than most of most other, or higher rate than the guidance has suggested because we just know that we're in a really high priced area. And it's definitely, in order for our members to be able to live safely in the community, they need to have this level of care.

Next slide. I think... Yeah, that was it. Thank you.

Jill Donnelly:

Great. Thank you so much, Nicole. And I do want to mention there are so many wonderful questions coming in through the Q&A. Thank you, everyone who's presented those. We do have time for Q&A at the end. We probably won't get to every question that's been asked, but they will be taken back. And where possible, responded to by DHCS. So thank you. Keep asking them. They're really wonderful questions. All right, and with that, we have one more wonderful speaker today. I'd like to introduce Yousaf Farook, Senior Director of Healthcare Services at Community Health Group.

Yousaf Farook:

Good afternoon, everyone. Thank you, Jill and Kathleen. Appreciate the opportunity to share some of the activity that we are involved in here in San Diego.

Who is Community Health Group? Community Health Group is a local health plan here in San Diego, California. We've been around for 40 years. We're a nonprofit organization. Currently, we're serving close to 330,000 members, majority of them being Medi-Cal recipients. We do have about 8,000 dual eligible, or CMC line of business as well. And come January 1st, 2023, we will be rolling those members over to our [inaudible 01:06:25] line of business.

And one thing that I have here that I want to mention is Community Health Group, we have 24/7, 365 days a year, live member services representatives who are trained in MAGIC. What is MAGIC? And want to talk a little bit about our MAGIC program, which is make a great impression on customer. All of our staff here at Community Health Group go through 48 hours, or two days of training and annually thereafter. They received at least 12 hours of training each year to make sure that we are trained in how to build relationships with our members. All the way from our member services staff to our case management. Even our facility staff go through this type of training because we do receive members who come to our building seeking help.

So, having a method to, or which allows us to communicate with our members and build rapport and build relationships is a key to our success and success of our programs. And this becomes significantly important once I get into and talk about our transition program that we have here at Community Health Group.

We are about eight miles from the US Mexican border. So, as you can imagine, 60 to 70% of our members are of Hispanic descent. And our employees represent the members that we serve. We have employees that also speak multiple languages, are from multiple ethnic backgrounds. And our mission here at Community Health Group is dedicated to maintaining and improving the health of our members by providing access to quality care, and offering exceptional service to diverse populations. And we live that each day by making sure that we're there for our members and we meet our members where they live or receive services in the community.

Next slide, please.

Community Health Group has elected to offer all 14 community support services this year. We started in January with eight community support services. And as a-

Yousaf Farook:

... eight Community Support services, and as of July 1st, have added the additional six, completing all 14. Now, I do want to mention that CHG has had, for the past six, seven years, CS-like services. For example, skilled nursing facility or SNF to assisted living facility transition program. We have had that for about four years now. SNF to home, as well, we've been providing those types of services to our members for the past four or five years. Home adaptation and modification has been here. Medically tailored meals, asthma remediation, and respite services.

Going back to transitioning members from skilled nursing facility to home or to assisted living facilities, we have done pilots here locally with Father Joe and Project 25, where we were identifying members way before Community Support services were allowed, and identifying those members, and then helping them

transition through some case management program, and finding housing, section 8 vouchers, for those members.

We have had dedicated staff here at Community Health Group that perform these activities. We have found that anytime we perform the activities internally, it gives us a lot of flexibility and all the data that we need to be able to make those decisions immediately and not wait on a referral or reaching out to other providers. So having some of that, all this activity done in-house does give us some leverage and the flexibility that we need to be able to authorize things in a timely manner. Especially if things are urgent, we're able to take actions much sooner than later. Next slide, please.

Some of the lessons that we have learned, obviously, dedicated staff here at Community Health Group. We currently have a staff of about four individuals, transitional care coordinators and CS and ECM coordinators, that work with our dedicated inpatient case manager staff, who are the lead care managers, essentially, out in the facilities, out in the community. As cases come up at the nursing homes or at the hospital level of care, our inpatient case managers work directly with these transitional care coordinators or ECM and CS coordinators to plan and coordinate services for our members.

We do use a multidisciplinary approach, and our multidisciplinary teams not only include members from within the health plan, but we also work directly with the hospital case manager, social worker, or facility or skilled nursing facility case manager or social worker, as well, and including the physicians. Community Health Group, for many years now, we have had a dedicated [inaudible 01:12:33] model where all of our nursing homes, and we're contracted with over 56 nursing homes here in San Diego, and our contracted [inaudible 01:12:44] group tends to, or takes care of, our members in those nursing home settings.

As members' needs come up, we hold these weekly interdisciplinary team meetings with our facilities and our staff internally, including our physicians, CMOs, and medical directors, who can work on a case trying to identify barriers and then identifying how we can resolve those barriers for our members.

We definitely use whole person-centered approach and ongoing training, especially in this COVID world. What we have noticed is that we had to do a lot more training for our providers, especially out in the community. There's been a lot of turnover and other staff stepping in to take place for providing case management or social work services, and our TOCs or transition of care coordinators are constantly working in conjunction with our inpatient case management teams to provide the trainings that are necessary to make sure that our members receive the appropriate level of care at the right place and at the right time.

And as previous presenters have mentioned, keeping open lines of communication is a key. Earlier in the presentation, when I talked about MAGIC, MAGIC is a program which allows us to grade any interaction that we have with our member. It's based on 33 points of MAGIC. We can actually record a conversation between ourself and a second person, and then using the grading methodology, actually score or give a score to that interaction to see how well we interacted with the individual, what the impact was. If you receive a lower score, that means you need additional trainings. If you get a high score, close to 33, then you're doing well. You're using all the MAGIC phrases and not using tragic words. That plays a huge role in how our staff interact with our providers and our members.

And then simply providing access to services. We reduced barriers. Since our case manager and transitional care coordinators work in the same building, we are able to communicate on a regular basis. Anytime a service is needed, we are able to provide those services in a much quicker fashion.

Then we also, in preparation for ECM and CS, we developed the ECM/CS portal. Our portal not only provides data to our providers, but also creates a work queue, which the provider and their staff can use to accomplish tasks. Because it's not simply enough to just... take care of those tasks, that helps us reach our goals. Next slide, please.

Referral for our nursing facility transition to ALF or home start with either an external referral or a referral from one of our physicians or inpatient case managers. As previous presenters have mentioned, one of the biggest challenges that we face with transitioning members from a facility or from a hospital to home or ALF is the question about who's going to pay for that stay or the room and board. Our TOCs have

developed relationships with local care coordination agencies that help with Assisted Living Waivers, which sometimes can be approved for the members. That way, they do not have to take on the full load of paying for the room and board, even though the health plan is providing all the ancillary services, the medical and other social needs of the member can be covered except the room and board. And sometimes that room and board cost becomes a barrier.

We might have a willing member who's willing to move or wants to go home, but because they do not have enough financial resources, they're unable to do so. We found that to be one of the biggest barriers, and Assisted Living Waiver has been one of those programs that has helped us accomplish those goals for our members. Next slide, please.

Same goes for when members are transitioning from facility to home, our transition of care coordinators work with the members and make sure that there's a plan. We involve the physicians, the families of the members, if necessary, to get them to the right place where they need to be. Next slide, please.

As I mentioned, we have been providing these services for the past four, almost five years. We have successfully transitioned about 400 members prior to January 1st, 2022. And since 2022, we have served over 63 members currently. Next slide, please.

Some of the challenges that we have encountered. Our nursing facility or ALF member hesitating or hesitation due to unknowns, and again, building rapport, using MAGIC to make sure that we can build that relationship between us and the member is very important, and taking the time to educate the member about the benefits and the opportunities that we have. We have seen that by doing that, we can reduce these challenges.

Difficulty reaching SNF staff. The way we have overcome that is by doing actual field visits to the facilities where we can actually meet with the staff or the member face-to-face and have these conversations in person instead of over the phone or via video conferencing.

Then, SNFs unfamiliar or unaware of the resources and processes to access resources. We definitely take the time to educate our SNF staff, especially if there's turnover. Our staff can go out to the field or via tele or via Zoom, provide those trainings for our members.

And then there's a shortage of ALFs that accept the waiver programs. Our TOCs are in constant search of vacancies around San Diego County. Once they build that relationship with an ALF or an entity, maintaining those relationships so that way we can make sure that future members can be referred to those providers are important. Next slide, please.

Our future plans include avoiding institution and early detection of these members that might, instead of, if they're out in the community, if we can help them stabilize and stay in their homes or go to an assisted living facility from home instead of hitting the institution, that's the key. We're exploring options like working with our CBAS centers, our SNFs, our IHA providers, and other providers in the community to identify these members earlier on before they actually get to institutions so that we can prevent those admissions and ultimately provide safe housing for these members. Next slide, please.

Just a quick success story. We had recently had a member, elderly member, with multiple chronic diseases. He was in a facility or a nursing home facility for over 60 days. Nursing facility thought that member had no income. Our TOCs and inpatient case manager team were able to work with the member and the providers to identify that the member did have social security income. Once we identified the income source, we were able to work with the member and the family. Actually, the member's sister was able to take the member into her home with some amount of rent being paid by the member. And we were able to successfully transition that member. He was very grateful for the fact that there were teams that were willing to listen and do multiple face-to-face visits and explain the process and help them along the way to accomplish their goals.

That's all I have. And thank you very much for your time.

Jill Donnelly:

Thank you so much, Yousaf. That was wonderful. All right. We are almost at the end of our time. We did want to mention, again, that there is non-binding pricing guidance available. There were a few questions in the Q&A about rates and how payment is structured for some of these Community Supports. DHCS does have some guidance on the website.

If you are interested in becoming a Community Supports provider, maybe you were inspired by one of the presentations today, please reach out to your local health plan to determine what the provider application process is like with that plan.

There were also some questions that came through around referrals. There are a lot of different ways that folks can be referred into these supports. Again, please reach out to the client's managed care plan if you think they may be eligible. You can find out if the plan is offering the Community Support in your county and what the process is for referring them in.

Eligibility, the eligibility for the program we've gone over today is also outlined in the DHCS Community Supports policy guidance. Really wonderful resource and reference material, also on the website. We also wanted to mention that DHCS is hosting an all-comer CalAIM office hours, and this will be focused... They're going to be monthly for a while here. This next one will be focused on ECM long-term care population of focus, which will go live in January. This office hours will be held on September 22nd at 2:00 PM. The registration link is available through the DHCS website. We really recommend joining.

There will be more of these webinars coming up over the next few months. We are saying internally that October is housing month, so tune back in for some really wonderful webinars on various viewpoints on housing services through ECM and through Community Supports.

I think we may... Thank you to Elizabeth for throwing that in the chat. I think we may be out of time to go through a lot more Q&A. Maybe I can throw one question that has come up a couple times in the Q&A to Neha. There's a question asked about whether these two Community Supports are available to folks who are dually eligible for Medicare and Medicaid, or Medi-Medis. Neha, I wonder if you could jump in and answer that one. Are duals eligible?

Neha Shergill:

Yeah, great question. So, yes, in fact, all the Community Support services are available to dual eligible beneficiaries as long as they meet the eligibility criteria for that given Community Support.

Jill Donnelly:

Great. Thank you.

Anastasia Dodson:

This is Anastasia. I think I'll just add that in talking with our Medicare/Medi-Cal plans, formerly the Cal MediConnect plans, we are emphasizing to them that, again, they have responsibilities as Medi-Cal plans as well as Medicare plans. And so the point of having one plan that coordinates across Medicare and Medi-Cal benefits is that they should be able to link up even within the dual eligible's primary care provider on the Medicare side, and thinking about all the connections that need to be made there.

And of course, nursing facility stays sometimes are often initially paid for by Medicare. So having that upfront window, thinking about how to avoid a nursing home stay or transition out if it's covered by Medicare, again, those MMPs, they're in a good position to be able to have visibility across the whole range of services. Thanks.

Jill Donnelly:

Thank you. Absolutely. And maybe we have time for one more. We got a lot of really wonderful questions about the interaction between ECM and Community Supports, how they intersect, how they potentially may overlap. So another question for Neha, can you clarify how these programs intersect? Is it possible

for a member to simultaneously get ECM and one of these Community Supports that we've been discussing?

Neha Shergill:

Of course. The answer is yes, a member can receive ECM and simultaneously receive the care management included in those two Community Supports. They're considered supplemental to ECM and not duplicative.

Jill Donnelly:

And can you say just a little more because I think there's some fear that they may be providing the same service in some situations.

Neha Shergill:

Sure. The care management included in these Community Supports is really focused on securing and transitioning members into community-based housing. And they're doing everything they can to really help the member get housed safely and stably. ECM care managers, on the other hand, are broadly focused on coordinating a wide range of services and care and supports for members. That includes administering a comprehensive assessment and care management plan. In the instance that you mentioned, the member's ECM lead care manager would remain primarily responsible for the overall coordination of the member's care across delivery systems.

Jill Donnelly:

Great. Thank you. I think we've run out of time, so I want to thank everyone who has joined us today for this presentation, for your wonderful questions, and for all of our really incredible presenters today. These slides will be available, as will this recording, on the DHCS website shortly. And then the next Community Supports Spotlight webinar will be on October 20th, and it is housing month. Any questions, please shoot them over to this shared mailbox, CalAIMECMILOS@dhcs.ca.gov. We want to thank you all. Have a wonderful rest of your day.