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SPEAKERS

Alisa Chester
Dana Durham
Cori Mallonee
Stephanie Conde

Alisa Chester:

All right, well good afternoon and thank you for joining today's webinar, the CalAIM Subacute Care Facility, Carve-In Office Hours. This session is part of an educational webinar series about the Subacute Care Facility Carve-In. My name is Alisa Chester and I'm a Director of Medicaid Policy & Programs with the Aurrera Health Group. You go to the next slide. Just a few notes before we begin the webinar. This webinar is being recorded. The webinar recording and slides will be posted to the DHCS Subacute Care Facility Long-Term Care Carve-In web page shortly after today's presentation. Participants are currently in listen-only mode, but we will be unmuting folks during the Q&A discussion period. To participate in the Q&A discussion, please use the raise hand feature and our team will unmute you. You can also use the chat feature at any time to submit your questions.

Alisa Chester:

Next slide. We would ask that folks, take a moment now to add your organization's name to your Zoom name so that it appears your name, dash organization. This helps us track any questions that we may need to follow up on. In order to do so, you can hover over the participants icon at the bottom of the window, hover over your name, select rename, and enter your name and organization as you would like it to appear. Now I'm going to turn it over to Dana Durham, the Chief of the Managed Care Quality and Monitoring Division at DHCS.

Dana Durham:

Thanks so much, Alisa. So on the slide you'll see our agenda for today's office hour session. We'll start off with a brief overview of Subacute Care Facility Carve-In and reiterate key policy requirements and promising practices. Now after that, we'll have time to discuss stakeholder questions. We'll kick off the question and answer period by addressing the questions that we received in advance of today's session and several we received on recent webinars before we open it up for questions from attendees. Finally, we'll wrap up with next steps and closing. Next slide please. To level set. We'll start with an overview of the Subacute Care Facility Carve-In.

Dana Durham:

Next slide. So, on January 1st, 2024, all Medi-Cal Managed Care Plans are responsible for the full long-term care services benefit. Now that includes adult and pediatric subacute care services. All fee-for-service Medi-Cal members residing in a Subacute Care Facility were mandatorily enrolled into a Medi-Cal Managed Care plan for their Medi-Cal covered services. The Subacute Care Facility Carve-In is intended to standardize Subacute Care Facility services coverage under the managed care plans across the state. And the purpose of that is really to advance a more consistent, seamless, and integrated system of managed care. Next slide. I'll now turn it over to Cori Mallonee with our Subacute Contracting Unit. Cori.

Cori Mallonee:

Thank you, Dana. Managed care plans must offer a contract to all Subacute Care Facilities within a managed care plan's service area that have a subacute care contract with DHCS Subacute Contracting Unit, or are actively in process of applying for a Medi-Cal Subacute Care contract and enrolled in Medi-Cal. Managed care plans must make sure that their members requiring subacute care services are placed in facilities with a contract with DHCS Subacute Contracting Unit. And this applies to all managed care plans in all counties. To ensure access to care during the transition, Department of Health Care Services Subacute Contracting Unit will process applications for new contracts as quickly as possible and we'll post a list of facilities that have applied for a contract on the DHCS Subacute Contracting Unit website to allow plans to continue to reimburse those facilities during the application process. Managed care plans may instruct non-DHCS contracted facilities that they must contract with DHCS or be actively in the process of applying for a Medi-Cal Subacute Care contract in order to receive payment. Back to you, Dana.

Dana Durham:

Thanks, Cori. Next, we'll talk about network readiness requirements by subacute facility type. Network readiness requirements really mean overall, what is the managed care plan, what are the facilities that they're in contract with? Those make up the managed care plans networks and managed care plans are required to make every effort to assess the various provider types currently serving their members who reside in Subacute Care Facilities. And the plans are required to maintain an adequate network and ensure that care is not disrupted as well as ensuring that members receive timely care. For adult Subacute Care Facilities, managed care plans must attempt to contract with all facilities in the managed care plan's county or state region level. For pediatric Subacute Care Facilities, managed care plans must attempt to contract with all 10 Subacute Care Facilities. That's provided in both freestanding and hospital-based facilities statewide. Guidance on this policy of network readiness, what it means to have their network ready, has already been shared with the managed care plans.

Dana Durham:

So now that you know what the network requirements are, we'll turn next to the next slide and talk about Continuity of Care. Now it's important that members don't experience disruptions in care during the transition. So for members transitioning from Medi-Cal Fee-for-Service to Medi-Cal Managed Care, managed care plans must proactively reach out and attempt to provide 12 months of Continuity of Care for the Subacute Care Facility placement, and that means that they will offer a contract for those 12 months. Automatic Continuity of Care means that the members currently residing in a Subacute Care Facility, they don't have to request to stay there to receive Continuity of Care. And following that initial 12 months of automatic Continuity of Care, members may request an additional 12 months. And the reason for that 12 months is so that the contract between the plan and the facility can be worked out. The goal is never to move the individual, but to ensure that they continue to receive the care at the same place.

Dana Durham:

Next slide please. So next we'll talk about Continuity of Care in the instances that members have existing Treatment Authorization Requests. So Medi-Cal's Managed Care Program, managed care plans are required to support utilization management and that just basically means that one of their responsibilities is to look at services and improve or deny the authorization requests. So for members who are newly transitioned from Medi-Cal Fee-for-Service to Medi-Cal Managed Care, managed care plans are responsible for covering treatment authorizations that are approved by DHCS for up to three, six, or 12 months depending on the type of treatment authorization request. We'll cover those treatment authorization requests in the next few slides because if you're like me, you're starting to go, "Okay, which is which?"

Dana Durham:

A quick note, the MCPs in all counties expedite prior authorization requests for members who are transitioning from an acute care hospital to Subacute Care Facility. So that means if you're leaving a hospital and you've got a request to go to a Subacute Care Facility, those must be treated as urgent and reviewed in an expedited timeframe. So the next slide. So for members with existing treatment authorization requests residing in a Subacute Care Facility and newly transitioned to managed care, managed care plans are responsible for covering TARs that are approved by DHCS and provided under the Subacute Care Facility per diem for a period of six months after the enrollment in the managed care plan or for the duration of the treatment authorization request, whichever is the shorter of the two.

Dana Durham:

Managed care plans are responsible for covering all services in the TAR approved by DHCS provided in the Subacute Care Facility, exclusive of the Subacute Care Facility per diem rate for a period of six months after enrollment to the managed care plan or for the duration of the TAR, whichever is shorter. Subsequent reauthorizations for these two types of TARs may be approved for up to six months. For members that have been identified or meet criteria for prolonged care, reauthorizations may be approved for up to one year. Next slide.

Dana Durham:

A supplemental rehabilitation therapy service and ventilator weaning services may be separately authorized or reimbursed for eligible pediatric subacute patients. Reimbursement of these services is in addition to the per diem rate for pediatric subacute level of care services. An approved treatment authorization request is required for these services and is the responsibility of the facilities. Managed care plans are responsible for covering supplemental rehabilitation services and ventilator weaning services for TARs approved by the Department of Health Care Services and a Subacute Care Facility for a period of three months after enrollment in the managed care plan. And with these timeframes, they are for existing TARs, it does not prohibit a new TAR being requested. It just is the timeframe by which that new TAR must be requested. So next slide please. So, in the past we've mentioned the role of the Long-Term Care

Services and Supports liaison many times, but we really want to emphasize their role in supporting providers throughout the carve-in transition process.

Dana Durham:

Managed care plans are required to identify a Long-Term Services and Supports liaison to be a service, that really single point of contact for the service providers and the Long-term Services and Supports community. Liaisons will assist providers in addressing claims and payment inquiries and care transitions to support the member's needs. Managed care plans will share the LTSS liaisons contact information to their network providers and provide updates really on any changes that happen with that liaison. So if you're a Subacute Care Facility provider and have not yet been in contact with the LTSS liaisons for the managed care plan serving your county, please reach out to the Long-Term Care Transition inbox and it's shown on this slide and the team can provide you with the contact information.

Dana Durham:

Next slide please. So I want to talk a little bit about promising practices for authorizations. I just want to reiterate some tips and promising practices. So when it comes to new authorizations or reauthorization requests, managed care plans should communicate requests for any supporting documentation in a timely manner. Additionally, managed care plans and facilities may use contracts or policies or procedures to ensure clarity and coherent authorization process. That should include establishing escalation contacts at the managed care plan in the event an authorization delay is occurring and creating shared retroactive authorization policies that allow providers more time to submit authorization requests. Finally, managed care plans should provide easily understandable and readily available descriptions of the authorization request process. Subacute Care Facility staff should also ensure they have a clear understanding of the timing and processes to request reauthorization for residents. Now I'll hand it over to Alisa to discuss payments and billing.

Alisa Chester:

Thank you. All right, so under the directed payment policy for facilities, MCPs must reimburse the network provider providing subacute care services to a member and each network provider must accept the payment amount that they would be paid for those services in the fee-for-service delivery system. This means that subacute care providers should not experience any decreases in the payments that they receive. Only subacute care services or those services included in the per diem are subject to the state directed payment requirement. And there's a slight difference in this policy based on whether the county is newly transitioning. So in counties where extended coverage of adult or pediatric subacute care services is newly transitioning from Medi-Cal Fee-for-Service to Medi-Cal Managed Care on January 1st, MCPs must reimburse network providers for subacute care services at exactly the applicable Medi-Cal Fee-for-Service per diem rate. In counties where subacute care services are already carved in to Medi-Cal Managed Care MCPs must reimburse providers at no less than the Medi-Cal Fee-for-Service per diem rates. Next slide.

Alisa Chester:

The state-directed payment requirements do not apply to other types of payments such as provider incentives or pay-for-performance payments, subacute services provided by an out-of-network provider, or non-subacute care services. The state-directed payment requirements also do not apply to other services the member receives. These non-qualifying services are payable by MCPs in accordance with negotiations between the MCP and the provider. This means that MCPs and providers can negotiate ancillary services outside of the per diem rate. Next slide.

Alisa Chester:

MCPs are required to pay timely in accordance with prompt payment standards within their respective contracts and APL 23-020. DHCS expects MCPs to pay clean claims within 30 calendar days of receipt. And MCPs are highly encouraged to remit claims and invoices in the same frequency in which they are received. So on the next slide we have a few promising practices that we wanted to share. Subacute Care Facilities often do not have the financial reserves or as diverse of a payer mix as other providers and do rely on those prompt payments from MCPs. Shorter payment timeframes for clean claims can help support provider operations. In order to receive prompt payments, Subacute Care Facilities need to submit clean claims in a timely manner for MCPs to process the claims as they come in. Subacute Care Facilities may require additional support from the MCP as they build their knowledge of each MCP's separate payment processes.

Alisa Chester:

And a few promising practices to facilitate prompt billing and payment include, working collaboratively between the MCPs and the Subacute Care Facilities to ensure alignment in understanding what the claims requirements are. MCPs should also offer trainings, office hours, and open-door outreach approaches to subacute care providers, and Subacute Care Facilities should familiarize themselves with and leverage MCP resources including training materials and connecting with LTSS liaisons.

Alisa Chester:

Next slide. We've mentioned clean claims in previous webinar presentations, and we wanted to take a moment to reiterate that clean claims are claims that are processed without obtaining additional information from the service provider or from a third-party. There are several general steps facilities can take to help ensure they are submitting clean claims. First, they should validate billing codes with MCPs to ensure the appropriate codes are being utilized. Facilities should also confirm that certain elements line up such as the dates. The patient status code should also agree with the revenue code. For example, if the status code indicates leave days, the accommodation code must also indicate leave days. For bed holds, check regularly for residents on leave at an acute hospital or transferred to another LTC facility. Now I'm going to transition over to Stephanie Conde from the Managed Care Operations Division.

Stephanie Conde:

Good afternoon, everyone. Good to see you again. I'm going to go through some reminders. We have presented out on these as well already. So I want to go quickly because I know we want to get to the Q&A session. So current member enrollment – the current Subacute Care Facility members were enrolled in a managed care plan by choice or auto assignment effective January 2024. Members can expect to get a welcome card from their managed care plans. They received those in January. Members also received the plan identification card from their managed care plans with their welcome packet. As a reminder, members will need to show the member card and the BIC, the Medi-Cal Benefit Identification Card, when they go to appointments. If there is more than one plan option in a county, as a reminder, members can change their plan enrollment on a monthly basis just by calling Health Care Options and we provided the number. Again, as a reminder, providers can check the Automated Eligibility Verification System, AEVS, to check what managed care plan a member is enrolled in or if the member is still in fee-for-service for any various reason. Next slide please.

Stephanie Conde:

So enrollment or eligibility help. If a member needs help with their eligibility, they should contact their local county office. We have provided that link in the slide deck that we sent out. If a member is not able to enroll due to a mismatch in their address in our Medi-Cal eligibility database system, that member or authorized representative should also call the local county office. And just as a reminder, those members will stay in fee-for-service until they get their address updated in our eligibility system. For enrollment help into a managed care plan, members or authorized representatives should call Health Care Options. We've provided the link and then that phone number is on the previous slide. Next slide please. Now we have time for the Q&A. So I'll hand it back over to Alisa.

Alisa Chester:

Thank you. So if we could just go to the next slide, just really quickly a few logistics before we begin the discussion period. We're going to start with some questions and answers we received from the registration form. After we answer those questions, we're going to open it up to folks on the line here. To ensure that we can cover as many questions as we can, it's really helpful if you can submit your question in the Zoom chat function. And then if we have any follow-up questions for you, we may call on you. You can raise your hand and we'll unmute you. So just to start with some questions that we already received from the registration form, “What are the policy strategies being developed to expand the capacity for subacute beds?” And this is for Cori with SCU.

Cori Mallonee:

Thank you, Alisa. Managed care plans must ensure that if the member needs adult or pediatric subacute care services, they are placed in a healthcare facility that is under contract with us, the Department of Health Care Services Subacute Contracting Unit or is actively in the process of pursuing an application. To increase capacity for subacute beds, the Subacute Care Unit will expedite new applications for SNFs that would like to

participate in our program. Applications are available by contacting subacute2@dhcs.ca.gov. If a bed in the Subacute Care Facility is not available and a member is in an acute care bed who requires subacute level of care and a subacute bed, then the managed care plans must continue to provide authorization for acute care until the member can be placed into an available bed in the Subacute Care Facility. Beds designated for adult or pediatric subacute care cannot be used for swing beds.

Alisa Chester:

Great, thank you. And then another question for you, “Can you please review the subacute admissions criteria?”

Cori Mallonee:

Managed care plans must determine medical necessity using adult member's Medi-Cal Manual of Criteria following the California Regulations section 51124.5. For pediatric members, the criteria may be found in 51124.6 as well as the Welfare and Institution Code 14132.25 which lists additional requirements.

Alisa Chester:

Great. And then one last question from the registration forms, this is for MCOD. “Will there be any changes to the current process of determining share of cost?”

Stephanie Conde:

No, thanks for the question. The same processes are in place. Providers can check the AEVS system.

Alisa Chester:

Great. And then now I'm going to turn to some of the questions that we got in the chat. So from Bob Nydam from Totally Kids, “What is the remedy if the MCP has not reached out to establish a contract that we have made multiple overtures to establish a contract?” Dana, do you want to take this one?

Dana Durham:

Sure. Bob, would love for you to send us an email to our transitions inbox to let us know who's not reached out to establish that contract. I think as we've covered in the slides, the goal is not to move the individual and you can have a letter of agreement. We do want to make sure that you are actively talking to the managed care plan, but if they're not being responsive, please let us know and we'll work with them to be responsive.

Alisa Chester:

Great. And Bob, if you want to provide any additional context, feel free to raise your hand. If not, we'll go to a few more questions.

Dana Durham:

Bob, I will say, reach out to that inbox and then my staff will reach back to you with a secure email. Please don't put identifying information in the chat, but we'll reach out to you with a secure email to answer.

Alisa Chester:

Thank you. All right, and then from Lisa, "How do we renew the Continuity of Care contract?" Becky from our team put in some information there. So following the initial 12 month automatic Continuity of Care period, the member, authorized representative, or provider may request an additional 12 months of Continuity of Care by contacting the member's managed care plan. I think some additional information about that Continuity of Care policy is available in the APL, the Subacute APL, as well as the Continuity of Care APL.

Dana Durham:

That's great information. Do want to say as well, please work with your managed care plan during that initial 12 months to come into contract. As I said when I was going over that, that additional 12 months is available, but our hope is that you come into contract before you would need to request a second 12 months.

Alisa Chester:

Yeah. Okay, from Doug at Totally Kids, "Please describe the penalties given to MCPs when they do not pay within the 30 days. There is abuse against providers in this arena."

Dana Durham:

So the managed care plans have to pay 90% of all claims within 30 days. And really with the 30 day prohibition, we look at the universe of claims to make sure that 90% are paid. However, after a clean claim is submitted, there is interest that can be accrued after that forty-five days if you're a network provider. So if you've got a contract and aren't being paid within 45 days, then interest is something that you could collect from the managed care plan.

Alisa Chester:

Great. From Lorenzo, "Could you send out the questions received in writing prior to the call and DHCS responses included with the slides?" And then we also have a question from Rebecca, "Is it possible to get the slides and recording?" We are going to post the slides and the recording to the DHCS Subacute Care webpage in the next few weeks. For the responses that we've said out loud, there will be a transcript available and if you want anything in writing, you can send a note to the LTC transition inbox and we will send a response in writing. Okay. From Renee, and then Susan, I see your hand up, so I'll go to you after this, "If a patient changes managed care plan after a month or two, does the next managed care plan have to honor the original TAR dates that were in place as of 1/1/24?"

Dana Durham:

So the protections are really for the fact that we're transitioning a person without a choice, and so you would need to go through a new request for an authorization if the individual makes a choice to change managed care plans. But they're subject to requesting that authorization for the time period or can request Continuity of Care for that with the new plan. But it's not an automatic honoring as it is when the change is driven by something outside the individual's control.

Alisa Chester:

Great. And then Susan, I see your hand up, so I'm going to go to you next. So I will ask you to unmute and you can ask your question.

Susan:

Thank you, Alisa, how are you?

Alisa Chester:

Good. Good to see you.

Susan:

Likewise. And hello Dana, I have a question for you regarding the new claim form uniform billing form and our new LTC codes for claims. My question is, do the MCPs and the plans have a specific date they must implement this change? Or is the Department allowing each health plan to accomplish this on their own timeframe?

Dana Durham:

And I'm looking to see if Adrienne is on this call. Adrienne, are you on this call?

Alisa Chester:

I do see Adrienne here.

Dana Durham:

Yeah, Adrienne, can you answer that question?

Alisa Chester:

So the question was whether there were specific-

Adrienne:

Oh, okay. I was having problems unmuting, sorry. So the actual coding conversion that you're referring to is happening at the state. They are moving from a form that was a state form to the national billing code form. And so those code changes are very specific to fee-for-service and are not specific to managed care. So we request that all facilities that contract with managed care plans speak with their managed care plans on how they would like them to bill for their services.

Susan:

Yes, we've done that and we've come back with data that shows different dates based on each plan. So the question was raised this morning in a meeting whether or not the state has any deadline timeframe or penalties. For example, one plan will implement in April. Another plan has already implemented in January. So there's a variety.

Dana Durham:

Thanks for that information, Susan. Let us take that back and get a response to you in writing about the expectation regarding if there's a timeline by which we're going to say it has to be done or that the requirement can be no sooner than. So we'll take that back and get that information to everyone on this call.

Susan:

Thank you, Dana. And may I give a question to Stephanie?

Alisa Chester:

Yeah, please.

Speaker 5:

Hi Stephanie, nice to see you again. Today, I was made aware of the dental coverage changing on some residents without the resident making a change. What do you recommend?

Stephanie Conde:

I'll send you an email and you can send me the CINs back.

Dana Durham:

Yeah, I was going to ask the same thing.

Stephanie Conde:

Susan, what county are these folks in?

Susan:

Some of the counties were Los Angeles and Orange and it could be larger. I can bring it to you statewide if you would like that.

Stephanie Conde:

Well I'm just concerned because our Los Angeles and Orange counties are dental fee-for-service and so yeah, I think the best thing if you can, I'll send you an email and I'll make it secure and if you can send some CIN level details, we can look into those for you and work with our dental division.

Susan:

Thank you so much. Appreciate that.

Dana Durham:

And Susan, just to follow up, the only place where there is really a change driven by dental is in San Mateo. So, if someone is in Kaiser for San Mateo County, but they had previously been in Health Plan of San Mateo, they will be disenrolled from the Health Plan of San Mateo dental plan and receive services through fee-for-service. We've got great contacts and Kaiser has had to get a hold of fee-for-service dental and also Health Plan of San Mateo is being pretty active and helpful but did want to note that change that really is happening. So hopefully that helps some, Susan.

Susan:

It does. That's a great point, Dana. Thank you so much.

Alisa Chester:

Great, thank you.

Susan:

Thanks, Alisa.

Alisa Chester:

We have one follow-up question. “Could that timeline be posted on the Medi-Cal website?” And I think that's related to the code conversion question. So I think once we get additional information and circle back, we will think about how best to distribute that information. Another question from Bob, "We are having specific issues with MCPs not contracted with pivotal children's hospital we utilize, we have met with them, but we have children unable to make appointments because these MCPs are not contracted or do not appear to be motivated to contract with pivotal children's hospitals. What is the remedy?”

Dana Durham:

So if there's a relationship, they can work to establish a single case agreement for continuing that care for the time period. Bob, I'd want to know a little bit more about specific cases because if it is a child who's getting services through CCS, which many of your children may be, that should not be a disruption because – and we'll send you an email for that and ask you to put the information in that too. CCS is not part of the managed care plans network except in specific counties which have whole child models.

Dana Durham:

So just want to make sure that there is an issue there with the specific child and that it's not part of the carve-out of CCS. If it is with the managed care plan, if there's an existing relationship that is continuing care, we will certainly work to encourage the plan to reach

single case agreements. And if the hospital will work with those, we would really encourage the hospital to as well. But the goal is to not disrupt care. But if the provider won't continue with the plan, then there is an obligation to really make sure that that transition is done really well. Since you're talking specifically about kids, most of them are eligible to have an enhanced care management provider who would work on coordinating things so that their care is really specific and tailored to their needs. But thank you for the question.

Alisa Chester:

Great, thank you. From Leah from Community Hospital – I'm not quite sure I understand this question. “What if there is an automatic enrollment into an IPA as well as managed health plan that is not contracted as IPA network provider and patient is long-term care patient in a subacute facility who needs procedure authorization?”

Dana Durham:

So some plans do delegate to IPAs. You can at the plan make a choice of a different provider if you want to. Often that reason the person is enrolled in that IPA is they either didn't choose a provider and/or their provider is in that IPA. Certainly Continuity of Care can be requested for services that that individual is receiving and should be. But the member can always choose to pick a different primary care physician who is not within that IPA. Hopefully that answers your question. Oh, Bob's asking what an enhanced care management is. It's a program that really works to coordinate all the needs of specific populations. It's a part of CalAIM and every plan has enhanced care management services and their populations of focus that are eligible for enhanced care management. And I would have to know specifics, but it seems likely that the children that are in a Subacute Care Facility would be eligible for enhanced care management. We can put a link to a description of enhanced care management in the chat, Bob, so you can look at it.

Alisa Chester:

Yeah, there is some information about populations that qualify for ECM in the subacute APL as well and subacute populations may be excluded, but we'll put some information about ECM in the chat there. Okay, next question. “We have several patients that were denied TARs, stating inpatient admission is not medically necessary. These patients have been with us subacute for a long time. Please explain.” Any thoughts there?

Dana Durham:

Can you read it again? Sorry, I was trying to find the link to the enhanced care management, so I was doing something else.

Alisa Chester:

Yes, no, no. No, totally.

Alisa Chester:

We can get our team working on that as well. “We have several patients that were denied TARs, stating inpatient admission is not medically necessary. These patients have been with us as subacute for a long time. Please explain.”

Dana Durham:

So if you can send an email to us and we'll send an email to you asking for specific information on the patient. We'll ask the plan to explain to us why they have made a different utilization management decision. They may not have all of the information, so hopefully it's just a matter of connecting you with the managed care plan and making sure they have all the information that's needed to make a decision. In managed care, you can also, if you don't like the decision that has been made, you should file an appeal on behalf of the beneficiary and you do that directly with the plan.

Dana Durham:

But one of the things the managed care plans are responsible for is utilization management and part of that utilization management is to make sure that people are in the right level of care. So it looks like what they've done is by looking at the information that's been supplied to them, that they think the individual should be at a lower level of care, but it probably is just not having all the information that they need to make an appropriate decision. That's my hope, but send us the information and we will follow up.

Alisa Chester:

Great. And then another question from Doug, “Concerning overdue rate increases that were due August 1st, 2023, who can we talk with? With the drawback of 10% effective May 11th, 2023, this delay is painful. We were counting on negotiated rates with MCPs and now that has been taken away too.”

Dana Durham:

Thanks for the question. We're going to have to defer that to our other partners within DHCS and we'll write that question down and answer everyone. We'll get our partners to answer that question and we'll send out the answer to everyone.

Alisa Chester:

Great. Let's see. I'm seeing the questions slow down in the chat. Does anyone have additional questions? If so, you can take a moment to put that into the chat there or raise your hand and our team will find you and unmute you. So I'll just give folks a moment here.

Alisa Chester:

All right. Not seeing any questions, I think we can move forward, but please do if you think of any additional questions, go ahead and place those in the chat. All right, so in the last few minutes we'll share some resources on the Subacute Care Facility Carve-In. You can go to the next slide. This slide has links to additional resources, updates on the

Subacute Care Facility Carve-In, including policy guidance and information on webinars and registration will be posted to the main webpage on the Subacute Care Facility Carve-In.

Alisa Chester:

We also have newly posted SNF and Subacute Care Facility Carve-In Resources for Managed Care Plans on the webpage. The document provides information on contracting requirements, promising practices, and suggested model contract language for the SNF and Subacute Care Facility Carve-Ins. Next slide. Okay, well thank you again for your time and for your continued engagement on the Carve-In. If you have any additional questions that were not addressed during this webinar or if you would like an answer in writing, you can email LTCtransition@dhcs.ca.gov. We've put that email in there several times and have noted that we will specifically follow up with a few folks on their questions. So, thanks again and I hope you have a great afternoon.