CalAIM: Subacute Care Facility Carve-In Office Hours

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

February 14, 2024

Meeting Management

- This session is being recorded.
- Participants are in listen-only mode but can be unmuted during the Q&A discussion.
  - Please use the "Raise Hand" feature and our team will unmute you.
- Please also use the “chat feature” to submit any questions you have for the presenters.

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- Click on the “Participants” icon at the bottom of the window.
- Hover over your name in the “Participants” list on the right side of the Zoom window.
- Select “Rename.”
- Enter your name and add your organization as you would like it to appear.
  - For example: Alisa Chester – Aurrera Health Group

Agenda

Topics	Time
Welcome and Introductions	2:30 – 2:35 PM
LTC Carve-In: Overview of Subacute Care Facility Carve-In	2:35 – 2:40 PM
Overview of Key Policy Requirements and Promising Practices	2:40 – 2:55 PM
Stakeholder Q&A	2:55 – 3:25 PM
Next Steps and Closing	3:25 – 3:30 PM

Subacute Care Facilities Carve-In Overview

DHCS

Subacute Care Facility Carve-In Overview

- Effective January 1, 2024:
  - Medi-Cal Managed Care Plans (MCPs) in all counties now cover adult and pediatric subacute care services under the institutional LTC services benefit.
  - All Fee-For-Service beneficiaries residing in an adult or Subacute Care Facility are mandatorily enrolled into a Medi-Cal MCP.

Subacute Care Facility Carve-In Goals:

- Standardize Subacute Care Facility services coverage under managed care statewide.
- Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.
- Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal members in Subacute Care Facilities.

Overview of Subacute Care Facility Carve-In Key Policy Guidance

DHCS

Contracting with DHCS' Subacute Contracting Unit (SCU)

MCPs must offer a contract to all Subacute Care Facilities within the MCP's service area(s) that have a Subacute Care Contract with DHCS' SCU or are actively in the process of applying for a contract.

- MCPs must make sure that their members requiring subacute care services are placed in facilities with a contract with DHCS' SCU. This applies to MCPs in all counties.
- MCPs may instruct non-DHCS contracted Subacute Care Facilities that they must contract with DHCS or be actively in the process of applying for a Medi-Cal Subacute Care Facility contract in order to receive payment.
- To ensure access to care during the transition, DHCS SCU will process applications for new contracts as quickly as possible and will post a list of facilities that have applied for a contract on the DHCS SCU website to allow plans to continue to reimburse those facilities during the application process.

If your facility is not already contracted with DHCS' SCU, please request an application from Subacute2@dhcs.ca.gov as soon as possible.

Network Readiness Requirements: By Subacute Facility Type

MCPs are required to make every effort to assess providers currently serving Members residing in Subacute Care Facilities and maintain an adequate Network with them to ensure care is not disrupted and Members receive timely care.

Adult Subacute Care Facility Network Readiness Requirements

- MCPs must attempt to contract with all adult Subacute Care Facilities in the MCP's county.

Pediatric Subacute Care Facility Network Readiness Requirements

- MCPs must attempt to contract with all pediatric Subacute Care Facilities (provided in both freestanding and hospital-based facilities) statewide.

More specifics on the adult vs. pediatric subacute care network requirements are in the Network Readiness Guide.

Continuity of Care

MCPs must automatically provide 12 months of continuity of care for the Subacute Care Facility placement for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care.

- This continuity of care protection is **automatic** – Members do not need to request to stay in their facility.
- Following their initial continuity of care period, Members or their representatives may request an additional 12 months of continuity of care.

Continuity of Care: Members with Existing Treatment Authorization Requests

Effective January 1, 2024, for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, MCPs are responsible for covering treatment authorization requests (TARs) that are approved by DHCS for up to 3, 6, or 12 months, depending on the type of TAR.

- The next slides review the following types of TARs:
  1. TARs for adult and pediatric subacute services under the per diem rate
  2. TARs for adult and pediatric subacute services exclusive of the per diem rate (except for pediatric supplemental rehabilitation therapy services and ventilator weaning services)
  3. TARs for pediatric supplemental rehabilitation therapy services and ventilator weaning services

- Note: MCPs in all counties must expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to a Subacute Care Facility.
  - Prior authorization requests for members who are transitioning from an acute care hospital must be considered expedited, requiring a response time no greater than 72 hours, including weekends.

Continuity of Care: Members with Existing Treatment Authorization Requests

1. For Adult and Pediatric Subacute Care Services Under Per Diem Rate

- MCPs are responsible for covering TARs that are approved by DHCS for a period of six months after enrollment in the MCP, or for the duration of the TAR approval, whichever is shorter.

2. For Other Services Exclusive of the Per Diem Rate

- MCPs are responsible for covering all other services in TARs approved by DHCS for a period of six months after enrollment in the MCP, or for the duration of the TAR, whichever is shorter.

- Subsequent reauthorizations may be approved for up to six months.
- Reauthorizations may be approved for one year for Members who have been identified or meet the criteria of "prolonged care."
  - Prolonged Care classification recognizes that the medical condition of selected Members requires a prolonged period of skilled nursing care.

Continuity of Care: Members with Existing Treatment Authorization Requests

3. For Pediatric Supplemental Rehabilitation Therapy and Ventilator Weaning Services

- MCPs are responsible for covering supplemental rehabilitation therapy services and ventilator weaning services for TARs approved by DHCS in a Subacute Care Facility for a period of three months after enrollment in the MCP.
  - Subsequent reauthorizations may be approved for up to three months.

Long-Term Services and Supports Liaison

MCPs must identify an individual, or individuals, to serve as the liaison to the Long-Term Services and Supports (LTSS) community, including Subacute Care Facilities.

- The LTSS Liaison must serve as a single point of contact for service providers in both a Provider representative role and to support care transitions.
- LTSS liaisons are required to receive training on the full spectrum of rules and regulations pertaining to Medi-Cal covered LTC, including resident rights under State and federal law.
- The Liaison is intended to assist service providers with:
  - Addressing claims and payment inquiries, and
  - Care transitions among the LTSS provider community to support Members' needs.
- MCPs will share their LTSS Liaisons' contact information to their Network Providers and update Providers regarding any changes to LTSS Liaison assignments.

Promising Practice: Authorizations

- If additional information is needed for service authorization, MCPs should communicate requests for supporting documentation in a timely manner.
- MCPs should provide easily understandable and readily available descriptions of the authorization request process and timeframe for LTC services.
- Ensuring staff at facilities have clear understandings of timing and processes to request reauthorization for a resident whose existing authorization is nearing the end date.
- MCPs and facilities may use contracts or policies/procedures to ensure clarity and smooth authorization processes, including establishing MCP escalation contacts for facilities if authorization delays occur and creating retroactive authorization policies.

Facility Payment

Under the Directed Payment Policy for Facility Payments, MCPs must reimburse a Network Provider furnishing adult or pediatric subacute care services to a Member, and each Network Provider must accept the payment amount the Network Provider would be paid for those services in the FFS delivery system.

» MCPs in counties where extended coverage of adult or pediatric subacute care services is ***newly transitioning*** from Medi-Cal FFS to Medi-Cal managed care on January 1, 2024, must reimburse Network Providers of adult or pediatric subacute care services for those services at **exactly** the applicable Medi-Cal FFS per diem rates.

» MCPs in counties where adult or pediatric subacute care services are ***already*** Medi-Cal managed care Covered Services must reimburse Network Providers of adult or pediatric subacute care services for those services at **no less than the Medi-Cal FFS per-diem rates** applicable to that particular type of institutional LTC provider.

Other Payment Requirements

- The state-directed payment requirements apply only to payments made directly for adult or pediatric subacute care services rendered, and do not apply to other types of payments, including but not limited to, Provider incentive and pay-for-performance payments.
- The state-directed payment requirements do not apply to any other services provided to a Member receiving adult or pediatric subacute care services such as, but not limited to, subacute services provided by an Out-of-Network Provider or non-subacute care services.
  - These non-qualifying services are payable by MCPs in accordance with negotiations between the MCP and provider.
- MCPs and providers can negotiate ancillary services outside the per diem rate.

Payment Processes Including Timely Payment of Claims

MCPs are required to pay timely, in accordance with the prompt payment standards within their respective Contracts and APL 23-020 Requirements for Timely Payment of Claims, or any superseding APL.

- DHCS expects MCPs to pay clean claims within 30 calendar days of receipt.
- MCPs are highly encouraged to remit claims and invoices in the same frequency in which they are received.
- MCPs must ensure that providers of subacute care services receive reimbursement in accordance with these requirements for all qualifying services regardless of any subcontractor arrangements.

Promising Practice: Prompt Claims and Payments

- Shorter payment timeframes for clean claims can help support provider operations in Subacute Care Facilities
- MCPs and Subacute Care Facilities should work collaboratively to ensure alignment in understanding claims requirements.
- MCPs should offer trainings, office hours, and open-door outreach approaches for subacute care providers.
- Subacute Care Facilities should familiarize themselves with and leverage MCP resources, including training materials and connecting with LTSS Liaisons.

Tips for Clean Claim Submissions

- ✓ Validate billing codes with MCPs to ensure the appropriate codes are being utilized to ensure a clean claim.
- ✓ Verify that dates of service on the claim reflect only the dates for services rendered and verify that the dates of service on the claim match the approved dates within the authorization.
  - If the dates do not match, a reauthorization may be required.
- ✓ Confirm that the patient status code agrees 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.
  - Verify that the facility to which the resident was transferred is billed correctly.

Enrollment Update

Member Enrollment

- Current Subacute Care Facility Medi-Cal members were enrolled into an MCP, based on the member's selection or auto-assignment, effective January 1, 2024.
- What members can expect next:
  - Members received a Welcome Packet from their MCP in January 2024.
  - Members also received a health plan identification (ID) card from their MCP.
    - Members will need to show their Medi-Cal benefits identification card (BIC) and health plan ID card when receiving services.
- If there is more than one plan option in the county, members may change their plan enrollment on a monthly basis by calling Medi-Cal Health Care Options (HCO) at 1 (800) 430-4263.
- To determine which MCP to bill, providers can check the members' eligibility record via Automated Eligibility Verification System (AEVS).

Eligibility and MCP Enrollment Support

- **For Medi-Cal eligibility-related matters:**
  - If members have questions about their Medi-Cal eligibility or need to update their information (e.g., address), they should contact their Local County Office.
  - If subacute care member is not able to enroll into an MCP due to a mis-match in their address and county code in the DHCS Medi-Cal Eligibility Database System (MEDS), the member needs to contact their Local County Office to update their address.
    - These members will remain in Medi-Cal FFS until their address is updated.
- **For MCP enrollment assistance:**
  - Medi-Cal members or their representatives may contact Medi-Cal HCO for plan enrollment assistance.

Discussion of Stakeholder Questions

Question Logistics

- Q&A will begin with questions previously submitted via the Zoom Registration form or other forums.
- DHCS will then provide time for open Q&A with today's Office Hours stakeholder audience.

To ensure DHCS covers as many questions as possible, please follow the guidelines below:

- Please submit your questions via the Zoom Chat function.
- If your question is chosen and you would like to provide more context or clarification, please use the "raise hand" function and a team member will unmute your line.

Next Steps

Subacute Care Carve-In Resources

- Subacute Care Facility Carve-In Transition: Information on the transition, policy guidance documents including the APL and forthcoming FAQs, as well as webinar information.
  - NEW: SNF and Subacute Care Facility Carve-In Resources for Managed Care Plans. The document provides information on contracting requirements, promising practices, and suggested model contract language for the SNF and Subacute Care Facility LTC Carve-In.
- Long-Term Care Carve-In Transition: Information on the LTC Carve-In initiative and SNF transition information.
- DHCS' Subacute Contracting Unit: DHCS webpage on Subacute Contracting Unit with list of contracted adult and pediatric Subacute Care Facilities.
- California Long-Term Services and Supports Dashboard: DHCS webpage on public-facing LTSS data dashboard to track demographic, utilization, quality, and cost data related to LTSS.
- MLTSS and Duals Integration Stakeholder Workgroup: Registration information for bi-monthly stakeholder workgroup meetings.

Thank you!

If you have additional questions that were not addressed during this webinar, please email: LTCtransition@dhcs.ca.gov

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