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Michelle Baass | Director

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SPEAKERS

Alisa Chester
Bambi Cisneros
Stacy Nguyen
Cori Mallonee
Dana Durham
Michael Jordan
Kyna Kemp
Dr. Laura Miller
Stephanie Conde

Alisa Chester:

All right. Good morning and welcome to the CalAIM Subacute Care Carve-In 101 for Subacute Care Facilities webinar. Thank you for joining us today. Go to the next slide. Just a few things to note before we begin the webinar. This webinar is being recorded. The recording and slides will be posted to the DHCS Subacute Care Facility, Long-Term Care Carve-In webpage shortly after today's webinar. Participants are currently in listen only mode, but we will be unmuting folks during the question and answer discussion. To participate in the Q and A, you can use the raise hand feature and our team will unmute you. You can also send us chats throughout the presentation and our team will be monitoring those.

Alisa Chester:

This webinar will include several opportunities to ask questions. We'd like to ask you to take a moment to add your organization to your Zoom name. In order to do this, you can click on the participant's icon at the bottom of the window, hover over your name, select rename, and enter your name as you would like it to appear. We have some great presenters today from the California Department of Healthcare Services and now I'm going to turn it over to Bambi Cisneros, Assistant Deputy Director of Managed Care to kick things off.

Bambi Cisneros:

Thank you, Alisa and good morning everyone. Happy Friday. Thank you for your time in joining us this morning to go through our subacute 101 for facilities. So teed up on our agenda today we will be doing a quick background and overview on the Subacute Care Facility Carve-In, talking about the policy requirements and implementation plan as well as giving some tips and promising practices for how Subacute Care Facilities can prepare for the transition. And then also talk about our approach for member communications. We will include time for Q and A in between each of these segments. And then we'll leave some additional time in the end for next steps and closing. Okay, next slide please. So first to start we will give a brief overview on the Subacute Care Facilities Carve-In. We can go to the next slide please. Thank you. And so I think you all are tracking that under CalAIM there is a Long-Term Care Carve-In effort under benefit standardization and the Subacute Care Facilities is part of that Long-Term Care Carve-In umbrella.

Bambi Cisneros:

One portion of it is tied to the Skilled Nursing Facilities and that was transitioned to the Medi-Cal managed care plan delivery system on January 1st, 2023. And we did issue an All Plan Letter in March to give our health plans guidance on that transition. Two upcoming transitions that are happening on January 1st, 2024 are for the Intermediate Care Facilities for the developmentally disabled and there's, the ICF/DDs. The ICF/DD Habilitative and ICF/DD Nursing Facilities or we call them Homes, are impacted by that transition as well as Subacute Care Facilities and that includes adult and pediatric.

Bambi Cisneros:

And so for the ICF-DD Carve-In, we also did release an All Plan Letter APL 23-023 in August that establishes guidance for our managed Care Plans on the ICF/DD transition and then for the Subacute Care Facility Carve-In, I think you may have seen the draft APL when we sent it out for comments in June. So we're working on finalizing that and there will be a separate APL for the Subacute Care Facility that you will see forthcoming. And so the subacute care services is going to be the focus of our webinar this morning. Okay, so we can go to the next slide please.

Bambi Cisneros:

And so the reason why we are doing a benefit standardization under CalAIM is because today in managed care there's different levels of coverage depending on the plan model type including levels of coverage per adult and pediatric Subacute Care Facilities. And so in our COHS counties, managed care plans provide coverage for both adult and pediatric subacute services as part of their institutional Long-Term Care services benefit. And that applies for the 22 COHS counties overall. And then in five non-COHS counties only subacute care services for adults are covered. And then pediatric members that need subacute care services would be dis-enrolled for managed care and then put into a Fee-for-Service after the second month for those members to continue getting services.

Bambi Cisneros:

And then in the remaining 31 counties that are non-COHS, managed care plans are responsible for those subacute care services from the time of admission into the facility and up to one month after the month of admission. Then at that point in time, members are then dis-enrolled from their plan and transferred to Fee-for-Service so the members can continue receiving their subacute care services. And so as you can hear, this could be confusing to the member especially experiencing county to county variants. And so we really wanted to standardize these benefits to improve the member experience statewide. You can go to next slide please.

Bambi Cisneros:

So what is changing is that on January 1st, 2024 we will have Medi-Cal managed care plans cover all of the Subacute Care Facility benefits statewide and the same benefit structure across plan models. So that means members who enter a Subacute Care Facility and would have otherwise been dis-enrolled from the plan to Fee-for-Service will need to remain enrolled in managed care. And they'll stay in their plan ongoing to continue receiving those services. And those members include – that will be transitioned to a plan – include those with other health coverage including private coverage and share of cost Medi-Cal beneficiaries in the Long-Term Care aid codes.

Bambi Cisneros:

Go to next slide please. So we have here listed on the slide the changes in the counties where the carve-in is going to be occurring. So as I mentioned, the adult subacute care services will be transitioning from Fee-for-Service to managed care within these 31 counties. So the adult subacute care services here and then the pediatric subacute care

services will be transitioning from Fee-for-Service to managed care in 36 counties, and that is listed on this slide as well. And we do also have an appendix that has a detailed list of counties and their associated managed care plans. So I wanted to provide that to you for reference. You can go to the next slide please. So we did touch on this a little bit about just the carve-in goal is really intended to standardize this coverage under managed care statewide to really reduce that county to county variability.

Bambi Cisneros:

And by doing so, we would have a more seamless and integrated system of managed care as well as have members – members will have access to the full array of services that are offered under managed care, which includes comprehensive care coordination and care management. And again these changes are going to be effective January 1st, 2024. And at a point in time where we had pulled the data, we have identified that approximately 1,700 Medi-Cal members in Fee-for-Service will be transitioning to a managed care plan. And this change also means that enrollment in a Managed Care Plan will be mandatory for those members are already residing in a Subacute Care Facility. And I think that covers the background and overview slides. I will now transition to Stacy Nguyen who is one of our Branch Chiefs in the Managed Care Quality and Monitoring Division.

Stacy Nguyen:

Thanks Bambi. So next we'll, go ahead and cover some key policy requirements in the forthcoming APL and we'll go ahead and start off with the network readiness requirements for our managed care plans. Managed care plans must develop a sufficient network capacity to ensure that member placement and subacute facilities occur within five business days, seven business days or 14 calendar days of a request and that's depending on the county of residence. Managed care plans are required to also make every effort to assess various provider types serving members residing in any Subacute Care Facility and maintain that network in order to ensure care is not disrupted and our members can receive timely care. So for example, when medically necessary, it's the managed care plan's responsibility to cover a member's transportation to dialysis as well as any other dialysis services provided outside of the Subacute Care Facility.

Stacy Nguyen:

Next slide. So for adult Subacute Care Facilities, our plans must attempt to contract with all facilities within the managed care plans county. If for any reason the county does not have any available Subacute Care Facilities, the managed care plan must extend contracting efforts to the state region level, which is Northern, Central or Southern California. And if the managed care plan does not have any available Subacute Care Facilities within the region level, then they must extend the contracting efforts statewide or just broaden it beyond the county and the region.

Stacy Nguyen:

For pediatric Subacute Care Facilities, managed care plans must attempt to contract with all 10 pediatric Subacute Care Facilities in the state. And if the plan and facility are unable to come to a contract, the plan must submit documentation indicating the reasons and provide explanations to the department for why a contract was unable to be secured. And next, I'll hand it off to Cori who is one of the Chiefs of our Subacute Care, Subacute Contracting Unit to go into a more detail about contracting with DHCS.

Cori Mallonee:

Thank you Stacy. Managed care plans must offer a contract to all DHCS contracted Medi-Cal subacute care providers within the managed care plan service area and to Medi-Cal certified non-contracted providers that are actively in the process of applying for a Medi-Cal subacute care contract. To ensure access to care during the upcoming transition, we will process applications for new contracts as quickly as possible and we'll post a list of pending applications on our website to allow the plans to continue to reimburse those providers during the application process. Once an application has been received, the provider will be added to the pending application list and will be considered to be in the process of applying for a contract until the application has been processed and a contract issued or the application denied due to the provider's inability to meet requirements for participation in our program. Next slide please.

Cori Mallonee:

The Medi-Cal Subacute Contracting Unit ensures the facilities are properly licensed embedded for the provision of life support (subacute care) prior to issuing Provider Participation Agreements, which is the name of our contracts. We process applications and issue contracts to both free standing and distinct parts SNFs and we conduct annual onsite facility visits to monitor compliance to Medi-Cal subacute regulations. We provide assistance to both contracted and potential providers regarding subacute care program. We investigate complaints regarding any Medi-Cal subacute care units. And in addition, we work with the California Department of Public Health Licensing and Certification to resolve clinical complaints and issues and we work with the Department of Healthcare Access and Information to ensure continued compliance with life support regulations and codes and we work with the Respiratory Care Board to ensure respiratory care providers are licensed. I will now transition over to Dana Durham. Thank you.

Dana Durham:

Thanks so much Cori. I get to talk about continuity of care. It's really 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 are going to automatically authorize 12 months of continuity of care for the Subacute Care Facility placement. This means that no one has to change where they are. Automatic continuity of care does mean you're living somewhere you don't have to move and you don't even have to request to stay in that facility. But following that initial 12 months of automatic continuity of care, members may request an additional 12 months of care. We hope that isn't needed because we do believe that the managed care plans will be able to get the facilities in contract during that time, but that is

available if it is needed. If a member is unable to access continuity of care as requested, the managed care plan must notify the member or their authorized representative with a written notice of an Adverse Benefit Determination.

Dana Durham:

A copy of that notice is also provided to the Subacute Care Facility in which the member resides. Next slide please. So, members with existing Treatment Authorization Requests also get continuity of care for that Treatment Authorization Request. Effective January 1st, 2024 from members residing in a Subacute Care Facility and transitioning from Fee-for-Service to manage care, managed care plans are responsible for covering TARs or Treatment Authorization Requests that are approved by Department of Health Care Services. We'll cover three types of Treatment Authorization Requests in the next few slides. Now it's important to note that managed care plans in all counties must expedite prior authorization requests for members who are transitioning from an acute care hospital to a Subacute Care Facility. Managed care plans must make all authorization decisions in a timeframe that's appropriate for the nature of a member's condition and those decisions must be made within 72 hours after the managed care plan receives relevant information needed to make the determination. Next slide please.

For TARs approved by the Department of Health Care Services that provides subacute services under the per diem rate, managed care plans are responsible for covering TARs for a period of six months after enrollment in the managed care plan or for the duration of the TAR approval, whichever of the two is shorter. For TARs for all other services outside the per diem rate, managed care plans are responsible for covering TARs for a period of six months after enrollment in the managed care plan or for the duration of the TAR, whichever is shorter. Subsequent reauthorization for these types of TARs may be approved for up to six months. Reauthorizations may be approved for one year for members who've been identified or meet the criteria for prolonged care. And prolonged care classification, that classification recognizes that the medical condition of selected members really does require a longer stay in a Skilled Nursing Facility or Skilled Nursing Care. Sorry. Next slide please. There's one final type of treatment authorization and that's for pediatric subacute care patients.

Dana Durham:

Supplemental rehabilitation therapy services and ventilator weaning services may be separately authorized and reimbursed for eligible pediatric subacute patients. Reimbursement for these services is in addition to the per diem rate for pediatric subacute care services. An approved Treatment Authorization Request is required for these services and it's the responsibility of the facility. Managed care plans 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 the enrollment in the managed care plan. And subsequent reauthorizations may be approved for up to three months. Next, we're going to talk about leave of absence or bed hold requirements. A leave of absence and bed hold – those are periods of time when a member may leave their facility while retaining the ability to return and the facility will continue to receive some payment.

Dana Durham:

Not may but will, let me be very clear on that one. During this period the managed care plan must provide continuity of care for members that are transferred from a Subacute Care Facility to general acute care hospital and then require a return to a Subacute Care Facility level of care due to medical necessity. Managed care plans must ensure that members have the right to return to the Subacute Care Facility and to the same bed if it's available or at a minimum to the next available room in the facility regardless of the duration of the hospitalization and that's consistent with federal regulations. Next slide please. Managed care plans must ensure that a Subacute Care Facility notifies the member, or the members' authorized representative in writing of the right to exercise the bed hold provision. Managed care plans are required to regularly review all denials of bed holds and ensure that the Subacute Care Facility and its staff have appropriate training on leave of absence and bed hold requirements. Speaking of looking at that managed care plans and their staff understand things, managed care plans have what's called the long-term services and support liaison.

Dana Durham:

And that's in this slide. It came up as I said it. Someone's good at forwarding the slides. Because facilities have reported challenges finding plan staff who understand or really are specifically trained in Long-Term Care issues, obtaining authorizations for post-hospital care and timely communication and problem resolution, managed care plans identifying individual or individuals and that's either plan staff or delegated entity staff to serve as liaisons for the Long-Term Services and Support provider community. These staff must be trained by the plan to understand the full spectrum of long-term institutional care and that includes payment and coverage rules.

Dana Durham:

Long-Term Services and Support Liaisons must serve as the single point of contact for facilities and both a provider representative role and to support care transitions as needed. And the real intent is to highlight the importance of having a dedicated individual or individuals that serve as a liaison between the managed care plan and Subacute Care Facilities. LTSS liaisons must assist facilities in addressing claims and payment inquiries and assist with the care transitions among the LTSS provider community and that's really to support a member's needs. So the managed care plans identify individuals and provide their contact information to their network of providers. And with that, I'm sure you all have questions because we have talked about a lot. So Alisa, I'm going to ask you to facilitate our questions.

Alisa Chester:

Thanks Dana. So if you do have a question feel free to enter it into the chat now or raise your hand and a member of our team will unmute you. We have one from Sarah. Earlier in the presentation did you say that managed care plans must offer subacute facilities a contract? I'm curious what this is based on because I recall that for the SNF LTC benefit, MCPs are encouraged to offer contracts but are not required. Stacy, do you want to take this one?

Stacy Nguyen:

. Yes. So, we took and we heard from some lessons learned too with the SNF Carve-In and so in order to ensure there's a robust network for all plans and for all members to access, the plans must offer a contract. It doesn't necessarily mean that one – it doesn't necessarily mean that the facility needs to accept the contract as is or accept it. There's obviously negotiations, et cetera. And if they're unable to come to a contract, we just want to make sure that there's a good faith effort and that the plans can report that information to us as well.

Alisa Chester:

Great, thank you. A question from Renee. Will we be able to have access to the meeting recording? Yes. The recording and slides will be posted to the DHCS Long-Term Care Subacute webpage in the next few days. We will. Thank you. Becky, add a link to that in the chat. Susan, I see your hand is up. I'm going to go ahead and ask you to unmute.

Susan LaPadula:

Hi, good morning everyone. It's Susan LaPadula. My question is in reference to the LTSS liaison. Statewide we're having difficulty as an industry accessing who these individuals are and there was a list a couple of months ago published by DHCS but it inadvertently excluded Northern California Kaiser contacts because we have separate contacts in the north part of the state versus the south. So when will we see an updated listing for all provider types that deal with LTSS? That would be our SNFs, our ICF/DDs, Subacute Care Facilities.

Dana Durham:

Alisa, I'll go ahead and take this question. That's a good question-

Alisa Chester:

Go ahead. I was going to look to point to you.

Dana Durham:

It's a good question. First of all, apologies that those individuals weren't on that list. I need to go back with my team and make sure that list is updated. And two things, we will make sure that the plan lets all their facilities that are applicable know who the contact is as well as we'll socialize that list again. But Susan, it's a great question noting that the Kaiser contacts aren't on there. For Northern California, I need to go back and get them and we'll get them. I hope to get that next week but I want to make sure that I have it right but we're also going to make sure that the plans are socializing that information with their providers as well. Thank you so much for the question.

Susan LaPadula:

Thank you to you and your team. We appreciate all your efforts.

Alisa Chester:

Thanks Susan. Another question in the chat from David. Did I remember correctly the pediatric subacutes will remain on Fee-for-Service at least for a specified period post-transition? Bambi or Dana?

Dana Durham:

Is that coming up later in the presentation? I do think we're talking-

Alisa Chester:

We are going to talk about facility payment.

Dana Durham:

Can we just hold that question until we have... David, I love your question. I just can't answer it and I'm not sure we had anyone present yet who can so we'll answer it when we get to the next time that we have questions.

Alisa Chester:

Great. And I just do want to clarify that all pediatrics will be carved into managed care effective January 1st, 2024. All right, I'm seeing a slowdown of questions. So I think we're going to keep going with our presentation and I'm going to pass it back to Bambi. Oh no. I'm going to pass it to Michael. Sorry about that.

Michael Jordan:

Thanks Alisa. And hey everyone, I'm Michael Jordan here from Capitated Rates Development Division with DHCS and I'll be talking a bit about the facility payment portion of this today. So, the payment policy that applies to the subacute carve-in is called the directed payment policy and this policy stems from requirements in California statute. So, under the directed payment policy for facility payments, managed care plans must reimburse a network provider that furnishes 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 the services in the Fee-for-Service delivery system. With that being said though there are differences in the directed payment policy based on the county of the managed care plan.

Michael Jordan:

Managed care plans and counties where the extended coverage of adult or pediatric subacute services is newly transitioning from Fee-for-Service to managed care on 1/1/24 must reimburse network providers for those services at exactly the applicable Medi-Cal Fee-for-Service per diem rate. So, in other words, no more and no less than the Fee-for-Service per diem rate. So then on the right side here, managed care plans in counties where adult or pediatric subacute care services are already existing Medi-Cal managed care covered services, these must reimburse network providers for those services at no less than the Medi-Cal Fee-for-Service per diem rates applicable to that

type of provider. So essentially, it's a floor at the Fee-for-Service rate if it's in a county where those services were already existing managed care services. Next slide please.

Michael Jordan:

All right, so this slide covers at a high-level what services the directed payment policy applies to with regard to subacute care services. So the state directed payment requirements do not apply to any other services provided to a member that is receiving these adult or pediatric subacute care services. Examples of services that do not apply include but are not limited to subacute services provided by an out-of-network provider and then also non-subacute care services that are being received by a member in subacute care. In attachment A at the end of the forthcoming APL there will be a list of adult and pediatric subacute care services that are included and excluded in the per diem rate. So just wanted to call that out as well. And next slide please. All right, this slide will provide more on payment processes. So firstly, managed care plans are required to pay timely and there are two main reference points here.

Michael Jordan:

So, the first is in accordance with the prompt payment standards within the managed care plans respective contracts. And the other is APL 23-020 or any superseding APL. As a reminder, DHCS does expect managed care plans to pay clean claims within 30 days of receipt. Managed care plans must also ensure that the subacute care providers receive reimbursements in accordance with all of these requirements for the qualifying services regardless of any subcontractor arrangements. And finally, managed care plans must have a process for these facilities, the Subacute Care Facilities, to submit electronic claims and then also to receive claims electronically. And now I will hand it off to Kyna for the next slide.

Alisa Chester:

Oh, Paola are you ready to present for CAD on PASRR?

Paola Ramos:

I see Kyna online.

Michael Jordan:

I think she's muted. Let me see if this works. Would that work?

Kyna Kemp:

Yes, thank you Michael.

Alisa Chester:

Sorry about that. Oh, got it.

Kyna Kemp:

So hi, I am Kyna Kemp from the Section Chief for the Pre-Admission Screening and Resident Review, also known as PASRR. And PASRR is a federally mandated program to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASRR requirements are applicable for all admissions to Medicaid-certified nursing facilities. Managed care plans are required to ensure that individuals who may be admitted into a nursing facility for a long-term care stay be preliminary assessed for a serious mental illness and or intellectual disability, developmental disability, or a related condition. At this time I will turn it over to Laura.

Dr. Laura Miller:

Good morning and thank you. I'm going to be speaking briefly about the population health management requirements, which you may know from prior webinars. MCPs must implement a PHM program that ensures that all members have access to comprehensive set of services based on their needs and preferences across the continuum of care, including basic population health management, transitional care services, care management programs, and community supports as appropriate. Authorizations need to be rendered in a timely manner for all members. There are specific timeframes for standard and expedited referrals or authorizations and plans must know when all members are admitted, discharged, or transferred from subacute facilities. Plans must ensure that all TCS or transitional care services are completed for all high risk members which include members receiving LTSS including subacute care services. We know that when there are transfers, things can fall apart. Transitions of care are a tender point, a fragile point, and we want there to be definite hands on and have nothing fall through the cracks with these transitions. Next slide.

Dr. Laura Miller:

So, you may know as well about the Workforce and Quality Incentive Program lovingly called WQIP. It flows from legislation AB186 and within WQIP, DHCS provides directed payments to facilities to incentivize workforce and quality through the program and it's hyperlinked so you can find a lot of really good information there. Any eligible provider furnishing qualifying skilled nursing services to Medi-Cal managed care enrollees can earn performance-based directed payments from the Medi-Cal MCPs that they contract with. Of note, freestanding pediatric Subacute Care Facilities and distinct part facilities are not eligible. I could wax a lyrical about the many parts of the WQIP but that hyperlink will take you there and at this point I'm going to transition it back to Alisa.

Alisa Chester:

Thanks Laura. I know you might have to hop soon. So I'm going to ask you one question in the chat for you from Renee. Will the MCP admission criteria requirement match the existing Medi-Cal criteria requirement?

Dr. Laura Miller:

That is a good question and I think we'll have to take that back. I don't want to say something that is not correct.

Alisa Chester:

Renee, could you clarify this question? Are you asking about subacute medical necessity criteria?

Dr. Laura Miller:

Renee, can you come off mute perhaps?

Alisa Chester:

I can see if I can find you here.

Dr. Laura Miller:

Renee Weeberly.

Alisa Chester:

Well, I think if that's the question that you're asking, the existing medical necessity criteria that is available in state statute as well as in the Manual of Criteria exist will continue into Medi-Cal managed care. So none of those criteria will change.

Dr. Laura Miller:

Great, thank you Alisa. Renee, I see that you're trying to unmute. You've also asked, do they have to follow the 6200 form for pediatric subacute? I do not know. That may be a question we need to take back or-

Alisa Chester:

Yeah. I think we'll go ahead and take that question back.

Bambi Cisneros:

Well, it sounds like there's some existing processes in Fee-for-Service today in terms of utilization reviews, medical management standards and TAR forms. And so to the extent, Renee, you can provide us any details or anyone else on this call that can give us a detail on current state, I think that would be really helpful for us to be able to address in detail, if you don't mind sending please.

Dr. Laura Miller:

Thank you.

Alisa Chester:

Great. I'm going to go through a few other questions that we have in the chat. From Erin, do MCPs have agreements with facilities or all counties to transition from Fee-for-Service to managed care coverage in place or will they have time to establish them? Stacy, I think this is a question for you.

Stacy Nguyen:

Thanks Alisa. Then we actually sent a response to Erin on there, but just reiterating that the managed care plans do need to develop the network with the Subacute Care Facilities and then we have of course our network readiness requirements. Let me look at Erin's question a little bit in more detail. And then in terms of establishing it, like Dana mentioned, there is going to be a continuity of care period that applies, but we can always elaborate on that more later and in further guidance.

Alisa Chester:

Great. A question from Tamara. Steph, I think this is for you. Is there someone that can help us dis-enroll manage plans on our current subacute residents? The plans are taking a long time to do so.

Stacy Nguyen:

Yeah. Yes, you can work with my team and we can put the email in the chat box. But yeah, our first request is that you do work with the managed care plans. If you are having issues then my team can step in. So we'll put the email in the chat box.

Alisa Chester:

Great. I think most of the other questions have actually been answered by Bambi. Thank you for your responses in the chat. Susan, I'll go ahead and ask you to unmute.

Susan LaPadula:

Thank you Alisa, I have a question for the team. Can the MCP plans use their own authorization form?

Bambi Cisneros:

Okay Susan, so typically that does occur, plans do have their own authorization forms, but it sounds like what Renee dropped in the chat, I wasn't entirely familiar with. So we would like to take that back and I think that's why we were asking if you can share with us the actual form names of what's being used today, we can certainly just make sure that we're all on the same page here with the Department and then share back with you all a response to that. But generally plans can have their own authorization forms but we'll like to take a look at what's existing today to see how we can streamline that. So if you can please share, that would be fabulous. Thank you.

Susan LaPadula:

I'll be happy to Bambi. I'll send it over. Thank you so much.

Bambi Cisneros:

Yeah, thank you so much. Thank you.

Susan LaPadula:

You're welcome.

Alisa Chester:

Thank you. All right, I think we're going to keep moving on our presentation. Bambi, I'm going to turn it over to you.

Bambi Cisneros:

Okay, great. Thank you so much and thank you for your questions thus far as well in keeping the dialogue going. So next we'll talk about how Subacute Care Facilities can prepare for the transition. And so we have some steps for consideration here. And so preparatory time is between now through December till the end of the year of course leading up to the January 1 transition. And so there's just some things to consider as you begin to work with managed care plans and contracting. And so we do encourage facilities to start working with their managed care plans. The plans should have already reached out to you to start those contracting discussions. If not I'm sure they will be reaching out shortly. Of course feel free to reach out to them as well just to engage and start those relationships. We do ask that facilities are responsive to plans when they do outreach because we are asking plans to build relationships and work towards contracting with these facilities.

Bambi Cisneros:

I dropped in the chat that managed care plans do have operational readiness and network requirements that they're required to adhere to here to the Department. And so that really only works if the facilities are also responsive and cooperative and collaborative with them as well. And so we do see that this relationship is really going to be crucial to the success of this transition. And so as you do work with your managed care plans, we do want to make sure that you find out how their LTSS liaison, who that is, and ask for more details about their authorization and billing processes so you can then determine what you need to do on your end to address your own internal workflows. And so just be sure to ask those detailed questions and I know some of those questions were raised here on the call as well.

Bambi Cisneros:

And again, if there are some plans that are interested in contracting with plans and they haven't reached out to you, you can also reach out to them. Certainly don't have to wait for the plans to reach out to you first just have that open dialogue and ask really good questions. And so we can go to the next slide please. Cori talked a little bit about the SCU process and contracting with them. And so, one of the steps here is that if you have not already begun to apply for a contract with the SCU unit in order to obtain that Medi-Cal subacute care accreditation, you must do so in order to get reimbursement. So make sure you work with your plans also to identify where current beneficiaries may be receiving ancillary or other services from providers who are not in their network so that managed care plans can work to contract with those providers as well.

Bambi Cisneros:

And so, I know we talked a little bit about just some lessons learned from the previous Skilled Nursing Facility transition. And so one of those examples is that there were

some members that had missed their dialysis appointments when those were outside of the facility. And so again, I think this is why it's really crucial for those communications to occur between the plan and the facility to know who are the different providers the facilities are working with so that the plans can work on having relationships and contracting relationships with them as well. And again, another crucial piece is to understand the managed care plans processes for submitting that referral for authorization and also the reauthorization. So processes, timing, protocols, all of those things because that will really ensure that the clean authorizations, clean claims will equal timely payments. So that's really important. We are requiring managed care plans to offer specific trainings and educational opportunities on the authorization process.

Bambi Cisneros:

And so please do participate on that, on those training opportunities. And in the next slide we do talk about some preparatory work for billing and payments and we also talked a little bit about that on this call too, just to understand the processes, the particular forms for authorizations including for bed holds and leaves of absence, and to know that ahead of the transition. Identifying who the plan representatives are who can help with the coordination of a member's care. So really important to know who the LTSS liaison is on the plan side. And then also determine whether your facility will be submitting electronic claims or invoices and then letting the managed care plan know of that. And then just be prepared to share that information with them as well as attending specific trainings that they offer, particularly around claims processing and what it means to have clean claims.

Bambi Cisneros:

And this really will ensure that when those claims are clean then the payments can be made timely. And of course, if your facility does anticipate cashflow challenges, please do work with your managed care plan on particular options that they can offer. I know this is one of the good things that came out of the public health emergency is plans did show that they were able to be nimble and can adapt to situations. And so again, just keeping that line of communication open and working with them and just talking with them about the situations that you're experiencing. So hopefully these are helpful, important tips and I think with that I will transition to Stephanie Conde, one of our Branch Chiefs from the Managed Care Operations Division to talk about our member communications and outreach plan.

Stephanie Conde:

Thanks Bambi. Good morning everyone. Next slide please. So I'm going to share a few details about the membership outreach that will occur in the next few months to let members know about the transition and about these changes. So DHCS will be mailing member notices directly to our impacted individuals and providing a link to the Notice of Additional Information. The NOAI (the Notice of Additional Information) will be posted on the DHCS website. And again that link will be provided in those notices via a QR code, a quick reference code. The NOAI is a FAQ. So any additional questions that members may have, we get a little bit more detailed than we do in the notices and again that will

be applicable to our members and then also on our website. We'll be sending 60 and 30 day notices that will be mailed ahead of January 1st, 2024.

Stephanie Conde:

We will also be mailing notices to the members' authorized rep that we have recorded in our Medi-Cal Eligibility Data System. We will be publishing the notices on the subacute carve-in member information page. Following the notices will be a call campaign to our members to also provide additional help our support to those members as we go through these changes. And then lastly, in order to ensure that our call centers and our agents are well prepared for any calls that may come in, we'll be providing training to our Medi-Cal Managed Care Ombudsman, our Long-Term Care ombudsman, the Medi-Cal helpline agents, and then our Medicare-Medi-Cal Ombudsman as well. I think that wraps it up for my side deck and I'm available for questions, but I'll hand it back to Alisa.

Alisa Chester:

Great, thank you. Are there any additional questions that folks have? We have a couple minutes right now so you can put those in the chat or raise your hand. All right, Susan, go ahead.

Susan LaPadula:

Thank you Alisa. Stephanie. Hello, how are you?

Stephanie Conde:

Hi Susan.

Susan LaPadula:

Hi.

Stephanie Conde:

I'm well, how are you?

Susan:

I'm good, thank you for asking. So I was at a conference and learned that perhaps our yellow packets that have been mailed for the redeterminations are no longer the color yellow. We ran out of paper. Is that an accurate statement?

Stephanie Conde:

I will need to take that back. I'm not sure, but anyone on the line from DHCS who may know or heard otherwise. I don't know Susan, but I could take that back pretty quickly and find out.

Susan:

Okay. Because as we're educating for our navigators and our reach community outreach, we may have to add that.

Stephanie Conde:

Yeah, good idea. I might be able to reach out while we're on the call and put it in the chat box, but let me look into it.

Susan:

Wonderful. Thank you Stephanie. Always a pleasure.

Stephanie Conde:

Likewise, thank you.

Susan:

You're welcome.

Alisa Chester:

Great. I see Renee has dropped in that 6200 form in the chat. Thank you. All right. Not seeing other questions so I think we're just going to keep moving with the slides here. So we have a few upcoming webinars that are open towards the public and geared towards Subacute Care Facilities and managed care plans. Registration information for these webinars is posted on the DHCS subacute carve-in webpage or will be posted before the webinar. Next slide. This slide links to additional resources, updates to 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. Go to the next slide. Just take a moment to thank everyone for your time. We look forward to your continued engagement on the Subacute Care Facilities Carve-In. If you have additional questions that were not addressed during this webinar, you can email the email address listed on that screen right there and I think it has been dropped in the chat. Thank you so much everyone, and we hope you have a good Friday.

Bambi Cisneros:

Thanks everyone.

Alisa Chester:

Thanks. Bye.