CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

LONG-TERM CARE LEARNING SERIES: LONG-TERM CARE POLICY UPDATE

Date: November 4, 2024

Time: 11:00 a.m. – 12:30 p.m.

Number of Speakers: 10

Duration: 1 hour 28 minutes

Speakers:

- Kristin Mendoza-Nguyen
- Bambi Cisneros
- Bonnie Kwok
- Laura Miller
- Joanna Aalboe
- Anthony Davis
- Stacy Nguyen
- Kyna Kemp
- Kate Bravo
- Michael Jordan

TRANSCRIPT:

Introduction

00:00:00 — Kristin Mendoza-Nguyen — Slide 1-2

Good morning. My name is Kristin Mendoza-Nguyen, I will be facilitating today's webinar. Thank you for joining for the LTC Policy Update part of the DHCS LTC Learning Series. Next slide. So just a couple of meeting management logistics just for today before we begin. This session is being recorded and the slides and the recording will be posted to the web page shortly after today's presentation. All participants are in listen-only mode and to submit questions for the presenters, please use the chat feature to submit questions and feel free to type any question in the chat during the presentation. Our team will be monitoring them throughout the session.

00:00:40 — Kristin Mendoza-Nguyen — Slide 2-3

We will be taking questions today through the chat only due to the anticipated volume. However, if folks need to add clarity to any questions, we will ask you to raise your hand, and the team can unmute you. Next slide. We would like to ask you to take a minute now to add your organization's name to your Zoom name, so it appears as your name, dash, organization. This allows the team to help track any questions that we need to follow up on with folks. You can click on the participant's icon at the bottom of the window, hover over your name in the participants list on the right side of the Zoom screen and hit rename. Okay, I will now turn it over to Bambi Cisneros, the Assistant Deputy Director of The Health Care Delivery System to start us off for today.

00:01:26 — Bambi Cisneros — Slide 4

Hi, everyone. Good morning and welcome. So, this is what we are planning to cover today. We have some topics teed up pertaining to background and overview of the Long-Term Care Learning Series. We will also want to go over an overview of the CalAIM foundational policies that are supporting long-term care members. Review some All Plan Letter updates. And there are some overview and reminders pertaining to very specific processes pertaining to the PASRR and the [SNF] WQIP program, as well as some reminders on some other key long-term care policies. And then we have some time in between each of these sessions to be able to have some Q&A. And we would also be using the chat. So, if you have questions during the presentation, please be sure to enter it there and then we will respond as promptly as possible. Okay, so then we can go on to the next slide, please.

LTC Learning Series Background & Overview

00:02:30 — Bambi Cisneros — Slide 5-6

So here, I think before we dive into the policy and program updates and discussions, we really wanted to just give some background and overview on the Long-Term Care Learning Series. So the Long-Term Care Carve-In, statewide institutional long-term care in Medi-Cal managed care is now live in 2024. So, we did this in a phased approach. On January 1st, 2023, we have carved in skilled nursing facility coverage in all counties. And then on January 1, 2024, managed care plans began covering long-term care in the subacute care facilities as well as ICF/DD Homes. And so, the three of these kind of long-term care provider sectors are what we're considering institutional long-term care. And they are all now carved

into the Medi-Cal managed care delivery system. And we'll plan to walk through these changes later in this session. Let me go to the next slide please.

00:03:36 — Bambi Cisneros — Slide 7

So, to support the CalAIM Long-Term Care Carve-In goal of achieving a seamless integrated system of managed long-term care, we focused our efforts on creating this Long-Term Care Learning Webinar Series. And we wanted this webinar series to be informed by your experience. And so, to do this, we held 11 interviews with impacted stakeholder groups. And these groups included the Medi-Cal managed care plans and plan associations, long-term care providers, regional centers and their associations, and the long-term care Ombudsman coordinators, as well as the Medicare Medi-Cal Ombudsman Program. And we learned a lot from those great discussions in addition to support the content of the Long-Term Care Learning Series.

00:04:25 — Bambi Cisneros — Slide 8

The next slide, please. So, the learning objectives for this particular Long-Term Care Policy Update session is that we would want you to walk away with an understanding of CalAIM policies that offer comprehensive services and supports that is available for a long-term care member as well as where to find resources. We also would want to share updates that are made to the revised Carve-In related APLs as well as updates to other relevant DHCS initiatives for long-term care providers. And this includes the skilled nursing facility Workforce and Quality Incentive Program or WQIP, as well as other relevant policy related to long-term care in managed care as we have identified during the stakeholder landscape assessment. And this includes topics such as the long-term care crossover claims and PASRR, which is the pre-admission screening and resident review process.

00:05:025 — Bambi Cisneros — Slide 8-9

Next slide, please. Thank you. So, we have several DHCS staff at the webinar this morning that are going to be presenting these policy updates. As I mentioned, we do have a wide range of topics to cover. And this slide really just identifies the DHCS staff that are here to discuss each of these provisions. And we also have a handful of other staff present to provide subject matter expertise during the Q&A session. So, with that, I will turn it over to Dr. Bonnie Kwok, from our Quality and Population Health Management team to discuss calculating policies that support long-term care members.

CalAIM Policies that Support Medi-Cal LTC Members

00:06:09 — Bonnie Kwok — Slide 10-11

Thank you, Bambi. I'm Bonnie Kwok, a Medical Consultant in the Population Health Management Division within Quality and Population health Management. And I'm also a family physician by training. And prior to joining DHCS, I was a primary care provider at a county FQHC, and I'm currently the Transitional Care Services lead. And TCS will be the primary focus of my presentation today. But before I jump into TCS, I'll provide a broad overview of CalAIM initiatives that support our Medi-Cal members with long-term care needs. Next slide, please. Our vision for Medi-Cal members with long-term services and supports needs is so that they can remain in the least restrictive level of care or setting that meets their needs and preferences and also optimizes their quality of life. These members may receive long-term services and supports through various CalAIM initiatives such as Transitional Care Services,

Enhanced Care Management, both under population health management as well as community supports under MCQMD. Next slide, please.

00:07:30 — Bonnie Kwok — Slide 12

Under CalAIM, we have the Care Management Continuum, which consists of varying levels of care based on the individual's level of risk. And I love food, and whenever I think about our population health management care management continuum, I think about a three-tiered cake. And in the lowest tier, we have Basic Population Health Management available for all our Medi-Cal managed care members. And they too can have their slice and eat their cake too. This Basic Population Health Management really focuses on preventive care, routine follow-up with primary care. And the next level up is Complex Care Management. And this tier focuses on our members with higher risk. For example, those with chronic conditions where they need closer follow-up in ambulatory care for these conditions. And at the very top, we have our members with the highest needs and that includes physical, behavioral health-related social needs, and that's Enhanced Care Management. And Transitional Care Services, as you can see on the right is really the icing on the cake that encompasses and is the thread across all these three tiers. And this is available for all members transitioning between care settings or levels of care. Next slide, please.

00:09:15 — Bonnie Kwok — Slide 13

Our goals for Transitional Care Services or TCS is, I'll start with the definition. A care transition or transitions of care is defined as a member transitioning from one level of care or one setting of care to another. And that means being discharged from a hospital to a skilled nursing facility or a skilled nursing facility to home. And our goals for Transitional Care Services is to support our members to have a safe and secure transition to the least restrictive level of care or setting of care that meets their needs and aligns with their preferences. And it's not good enough just to get them to that new setting or level of care. It's important that we are supporting them when they arrive in this new setting or level of care so that they're successful in this new environment. Next slide, please.

00:10:10 — Bonnie Kwok — Slide 14

At the center of our policies, including Transitional Care Services, is our members. And I'm going to take a quick pause to tell you about my great uncle who's actually a Medi-Cal member who's hospitalized right now in San Francisco. And he had a fall in August of this year and broke six ribs. He was re-hospitalized last week for a severe kidney infection in a new abnormal heart rhythm as well as low blood pressure. And as a Medi-Cal member with long-term services and supports needs, he plans are required to support him through this transition and provide a TCS Care Manager who serves as a single point of contact.

00:11:11 — Bonnie Kwok — Slide 14

And the plans cannot support members alone. The hospitals and skilled nursing facilities are jointly accountable to ensure that these transitions of care are successful and effective and efficient. And I just got off the phone with the hospitalist this morning and the plan for discharge is today to a skilled nursing facility, which is within walking distance from his home, which makes it a lot easier for my great aunt and their son to continue to provide that emotional and physical support at the SNF when he's

there. And the main emphasis for this slide is really that there really needs to be a lot of collaboration amongst plans, hospitals and SNFs to make this transition safe and effective. Next slide, please.

00:12:12 — Bonnie Kwok — Slide 15

And this is a really meaty slide. There's a lot of text here, and I'm not going to read through it, but I'm going to call out what I think is most important and most relevant for our members with LTSS needs. So, we actually had a phased approach for implementing Transitional Care Services. This started in January 1st, 2023, where plans were required to implement TCS for only our high-risk members. And our high-risk members includes those with LTSS needs. And we expanded our TCS requirements in January 1st, 2024, for all members to ensure that they're fully supported in this discharge planning process, in this transition of care so that they're successfully connected to all the needed supports and services post discharge. And generally, the requirements for plans for all members include knowing when a member is admitted, discharged or transferred, that each member is evaluated for all care settings appropriate to their needs that the facility is completing that discharge planning process as well as having a PCP to follow up post discharge.

00:13:38 — Bonnie Kwok — Slide 15

And an important emphasis for a responsibility for plans is ensuring that for those who need continued care management services, that they are connected to ECM, Community Supports, as well as other services and programs such as IHSS and HCBS post discharge. And as well as having prior authorizations processed timely, preferably while the member is still inpatient. And important difference between what our high-risk members receive as mentioned, like those with LTSS needs versus those who are in the lower-risk category is that, again, that high risk member has that single point of contact, also known as the TCS Care Manager. And the lower risk members have a dedicated team that could be plan staffed or plan delegates staffed available for a minimum of 30 days post discharge. And I say a minimum of 30 days because we all know that there can be ongoing needs in this transitional period, and we want to make sure that our members are fully connected to all the services and supports that they need in this transitional period.

00:15:06 — Bonnie Kwok — Slide 15-16

And highlight is that members are connected to their primary care provider, often the team member who may have the most knowledge and continuity with this member, and it's important that their medications are reconciled post discharge to ensure that those medications are filled and also that there's no gaps in understanding why they are taking those medications. Next slide, please. The role of a TCS Care Manager includes collaboration, communication, and coordination. We really like alliteration here at DHCS as well as doing so with a slew of different team members. And that includes the individual, the member themselves, as well as their family members or caregivers, the primary care provider, where they're heading to that discharging facility, the team there, to have that safe and successful transition.

00:16:20 — Bonnie Kwok — Slide 16

Again, the plans must identify this TCS Care Manager who's serving as a single point of contact. And the single point of contact provides longitudinal support and ensures that there is a fluidity across different settings and delivery systems post discharge. Additionally, it's important that the plans can provide the

responsible TCS Care Manager can communicate with both the TCS Care Manager and the discharging facility so that the TCS Care Manager can provide that care coordination as needed. Additionally, there's no limit in terms of setting or level of care for the TCS Care Manager and for those high-risk members that the TCS Care Manager's responsibility is to ensure that they are receiving all appropriate TCS as outlined in our policy guide. Next slide, please.

00:17:35 — Bonnie Kwok — Slide 17

To continue on with our TCS Care Manager responsibilities, one of the best practices that we promote is having the Care Manager work with the facility to ensure that care manager's name and contact information is integrated into the discharge documents. And this is where we strongly encourage timely and accurate data sharing practices. Additionally, Care Managers must identify members who again might be eligible for ongoing care management within Community Supports or Enhanced Care Management or other programs and that they should be making those referrals. Additionally, they should receive and review a copy of the discharge facility's provided instructions. One of our goals here at DHCS is also to reduce duplication of efforts and we are not asking for plans to make an additional discharge summary or discharge instructions, but to work with the discharging facility to ensure that there are the name and contact information for follow up with the TCS Care Manager... Excuse me, once the member is ready to be discharged so that they can be supported, especially in that very vulnerable period where a member leaves the facility and has not yet seen an ambulatory provider.

00:19:15 — Bonnie Kwok — Slide 17

And last but not least, ensure that all follow-up providers have access to the clinical information from the discharging facility, what happened during the inpatient stay, what was the plan moving forward and are those needs met? And I also want to note that it's important to note that there's a difference between the TCS Care Manager and the role of a long-term services and supports liaison in which plans are required to establish under the LTC Carve-In. And the TCS Care Manager is a member-facing role where this could be again, plan or plan delegate staff, whereas the LTSS Liaison is primarily a plan-staffed role and plans may contract with hospitals or skilled nursing facilities or providers to fill the role of the TCS Care Manager. Next slide, please.

00:20:24 — Bonnie Kwok — Slide 18

This is the last slide for Transitional Care Services. Under discharge communications plans are accountable for providing all Transitional Care Services through collaboration and partnership with discharging facilities so that this process is aligned with the member's care plan goals. And there's also quite a bit of text here and essentially, it's not sufficient for a member to receive the discharge instructions. The member and if family or caregivers are available, those members should be looped in to further understand what the member's needs and preferences are and that this information should be provided in a culturally and linguistically appropriate manner, such as that for my uncle who is non-English speaking and is currently hospitalized and being discharged to a skilled nursing facility today. And definitely the family, including myself, have been engaged. And that's the kind of transition that we hope for all our members to have that communication between the plan hospital and skilled nursing facility and having the member's voice part of this process.

00:21:46 — Bonnie Kwok — Slide 18

Additionally, the requirements for plans are fully outlined in our Population Health Management or PHM Policy Guide, which you can access on our DHCS webpage. And last but not least, we wanted to support our plans doing this challenging but definitely worthwhile work and we've provided some additional technical assistance through our recently published resource for Transitional Care Services for members with long-term services and supports needs. And this highlights promising practices for plans as well as a range of LTSS programs and services to support members with long-term services and supports needs under growing transitions of care. I believe this is the last slide, and I'm going to hand this off to Dr. Laura Miller from Quality and Population Health Management to talk more about Enhanced Care Management. Take it away, Dr. Miller.

00:22:57 — Laura Miller — Slide 19

Great, thank you so much Bonnie. So, it's my pleasure to do a brief overview on ECM and Community Supports. If we could have the next slide please, that'd be great. Yes. So, ECM and Community Supports are foundational parts of Medi-Cal's extension beyond traditional hospitals and healthcare settings into communities. I learned this as a primary care doc in East Oakland for about 20 years. There's only so much I can do sitting in my exam room with my metformin. It really takes getting outside the four walls and being able to really integrate with other systems outside of our health care system. So, both ECM and Community Supports are administered by our Medi-Cal managed care plans, two plan members in partnership with community-based providers. And that partnership is a keyword, absolutely key. So, ECM, Enhanced Care Management is a Medi-Cal plan contract requirement. All plans must offer ECM to certain populations of focus and the plans contract with community providers who deliver care management.

00:24:15 — Laura Miller — Slide 19

You can find the populations of focus on our website, but for instance, they include people experiencing homelessness, people who frequently use the ER or hospital, people who are living in community and at risk for going into a skilled nursing facility. So multiple populations of focus and we try to have both generalized ECM providers as well as specialized ECM providers. Community Supports are optional services that plans are strongly encouraged to offer. These are things like medically-tailored meals, home modifications, housing supports, transitional housing, respite, these really, really important things that support vulnerable members in achieving their best health. So, these are optional, and again, like ECM, plans contract with community providers who deliver the Community Supports. And some providers are both ECM and Community Supports providers, which is really wonderful. Next slide.

00:25:36 — Laura Miller — Slide 20

So, diving a little bit deeper and showing how ECM relates to Transitional Care Services. As we noted, ECM is a statewide benefit to provide comprehensive care management primarily through in-person interactions with members where they live, seek care, or prefer to access services. It is not conceived of as a telephonic relationship. It can of course have telephonic communication, but it is really in-person interaction focused. And it's the top tier of our care management. So that's the orange box, ECM. You'll see that of course there's Complex Care Management and that's for plan members with high or medium rising risk. And that is within the Medi-Cal plan. There is not a requirement for Complex Care Management to be community-based. And then Basic Population Health Management is really for all Medi-Cal members. Through the plan and really it is things like access to primary care, health care

maintenance services, all of those things that we know in the prevention realm that really support health and wellness.

00:26:58 — Laura Miller — Slide 20

And for any member cutting through those tiers of care management are the Transitional Care Services that Bonnie has spent so much time detailing. So, all Medi-Cal members do receive Transitional Care Services when they're transitioning between care settings. So specifically for this group today, the two populations of focus that really intersect with our focus today are adults living in community and at risk for long-term care institutionalization and adult nursing facility residents who are transitioning to the community. Really, when I think about my patients in East Oakland who were primarily elders, many of them would qualify for living in community and at risk for LTC. So, it's a really rich population of focus that is growing in its membership. And again, the aim of ECM for both of these populations is to really enhance people's ability to live independently and safely and remain connected to community and family.

00:28:16 — Laura Miller — Slide 21

Next slide. I'm going to draw your attention to the member spotlight. These are a series of publications that have been done by DHCS. The spotlight on long-term care populations was released in June. And I always say, it's great bedtime reading, it's not like reading a policy guide. It highlights the policies and resources and also includes member vignettes. So, the first vignette is an older adult living with Parkinson's who wishes to remain at home but needs supports to do so. And then the other vignette is an older adult who's temporarily in skilled nursing recovering from a stroke but would very much like to return home. Both those folks need this deep support to be able to achieve those goals. The spotlight also shows how Community Supports and traditional care services can really be integrated to best serve members and their caregivers. So, you can see there's a link there and it's one of a series of spotlights. So, at this point I will pass the baton to Joanna Aalboe to speak about Community Supports. Thank you so much.

00:29:42 — Joanna Aalboe — Slide 22

Thank you, Dr. Miller. Good morning, everyone. I'm Joanna Aalboe, and I'm excited to walk you through some key Community Supports under CalAIM that are decided to provide person-centered care for Medi-Cal members, including those in long-term care settings. These supports offer valuable resources that can enhance care options for members needing long-term services. So, I'll be focusing on eligibility, access, and services. So, let's get started on this slide let's talk about CalAIM Community Supports. These are medically appropriate and cost-effective services that have been pre-approved by DHCS. While managed care plans are not required to offer these services, they're strongly encouraged to do so as substitutes to other health care services or settings.

00:30:32 — Joanna Aalboe — Slide 22

Community Supports are managed by managed care plans but are delivered by community-based providers. These providers are experienced and skilled at serving members who need these services. The two Community Supports that are most applicable to long-term care, sorry about that. Medi-Cal members are Nursing Facility Transition and Diversion to Assisted Living Facilities and Community Transition Services and Nursing Facility Transitions to Home. Included at the bottom of this slide is a link

to Community Supports election spreadsheets, which shows MCP Community Supports selection statewide. All right, next slide, please.

00:31:15 — Joanna Aalboe — Slide 23-24

Let's look at eligibility for Community Supports members. Their caregivers or providers can contact MCPs directly to find out which Community Supports are offered and if the members are qualified. Each Community Support has its own specific eligibility criteria, and the available supports can vary depending on the plan and the county. It's important to note that Community Supports are voluntary, meaning members can choose whether or not they'd like to participate. These services are available to a wide range of members, especially those with higher needs such as individuals enrolled in Enhanced Care Management that Dr. Miller just went over. However, members don't have to be enrolled in ECM to access Community Supports, they're open to all eligible members. Next slide, please. There are a few different ways members can access Community Supports. First members may be directly contacted by their health plan or a Community Supports provider if they're identified as someone who can benefit from these services.

00:32:24 — Joanna Aalboe — Slide 24

MCPS are responsible for identified members who meet the criteria for Community Supports and reaching out to them. Second, health care or social service providers, including ECM and Community Supports providers can submit referrals on behalf of members. If a provider thinks a member qualifies but hasn't been identified by the health plan yet, they can submit a referral directly to the plan. And it's important to note that you don't need to be a clinician to refer somebody to these services. Lastly, members can also self-refer they or their families can contact their MCP and inquire about Community Supports by calling the member services number on the back of their insurance card. Next slide, please.

00:33:10 — Joanna Aalboe — Slide 25

So, as we discussed earlier of the 14 pre-approved Community Supports, there are two specifically aimed at helping individuals transition to less restrictive living settings. These are especially important for members at risk of institutionalization or re-institutionalization. So first we have the Nursing Facility Transition or Diversion to Assisted Living Facilities support. This service helps members who currently require nursing facility level of care or who qualify for that level of care to transition into assisted living facilities. Residential care facilities for the elderly or adult residential facilities. The goal is to offer them a less restrictive environment where they can still receive the care they need.

00:33:57 — Joanna Aalboe — Slide 25

A second support is Community Transition Services or Nursing Facility Transition to a Home. This one is designed to assist members in moving from a licensed facility to a private residence where they will be responsible for their own living expenses. It's a step towards greater independence and control over their living situation. DHCS is working on refining the definitions for these services to make sure there's clarity around which settings and services are covered. This should help increase uptake by making it easier for members and providers to understand what's available. Next slide, please.

00:34:37 — Joanna Aalboe — Slide 26

Lastly, we'll go over the eligibility criteria for Nursing Facility Transition and Diversion to Assisted Living Facilities. Nursing Facility Transition applies to individuals that have lived in a nursing facility for more than 60 days, are willing to transition to an assisted living facility and are able to safely live there with appropriate cost-effective supports. Nursing Facility Diversion applies to individuals who want to stay in the community, are willing and able to live safely in an assisted living facility, are receiving medically necessary nursing facility level of care, or meet the basic requirements for this level of care, and choose to continue receiving nursing facility level of care at an assisted living facility instead of going into a nursing facility. These services give members more control over their living arrangements, offering a less restrictive option to nursing facilities. Okay, and with that I'm going to now hand it over to Kristin who will lead the next Q&A session on Transitional Care Services, Enhanced Care Management, and Community Supports. Thank you so much.

CalAIM PHM, TCS, ECM, & Community Supports: Q&A Session

00:35:52 — Kristin Mendoza-Nguyen — Slide 27

Great. Thank you, Joanna, and thank you, Dr. Bonnie, and Dr. Laura for your presentation. So, we'll start with a couple questions. I know the team's been monitoring in the chat. There were a few in the beginning on Transitional Care Services. One question from Brianna at Mom's Meals for Bonnie, would the TCS Care Manager be responsible for referring members to Community Supports?

00:36:18 — Bonnie Kwok — Slide 27

Hi, Brianna, thanks so much for your question. Yes, the TCS Care Manager is responsible for evaluating and referring if the member is eligible to Community Supports as well as Enhanced Care Management. The role of TCS Care Manager is really to ensure that once a member leaves one setting or level of care that they can be further supported in whichever setting or level of care they are going to. And some of our members, as you know, do need that extra care management or support or other services that can really make sure really enhance their transition and support them in their needs as well as their preferences in that next destination. I see that your hand up, so feel free to share your additional thoughts or questions if you have that, Brianna.

00:37:17 — Brianna Moncada— Slide 27

Thanks so much, Bonnie, I really appreciate that. I was also wondering if, I think you mentioned that the TCS care coordinator is within the health plan realm, so hired by the health plan, but they could be working in a hospital or what are the other maybe types of or where might they be working and is there a list? Is there a way to get in contact with them or to know kind of where they might be located?

00:37:54 — Bonnie Kwok — Slide 27

Yes, I see that that was also your second question and I'm happy to answer that as well. We don't have a list of TCS Care Managers. And as you can imagine, having that list accurate is really critical here and we don't have a list. And so the best way to know if a member has a TCS Care Manager is to contact the member's managed care plan and to ask who that TCS Care Manager is and their contact information. We are working, there are discussions currently for example in the PHM service, Population Health Management service where we might be able to collect some of that data like the TCS Care Manager's name and contact. But that is still early on in the discussion. And I want to make sure that I answered

the second part of your first question of where else are these TCS Care Managers located? They can be a provider like an Enhanced Care Management provider on that team as well as in a skilled nursing facility. It depends who and where the managed care plan is contracting with. Was that helpful?

00:39:22 — Brianna Moncada— Slide 27

Yes, thank you so much. And so we're a medically tailored meal provider for Community Supports and so coordinating that care is always really helpful and that's why I was wondering. Just in relation to this group, we've seen that long-term care individuals really do well with meals. That's one of the best things keeping them in their homes, that nursing level of care. And so I was just curious, current service for meals is 12 weeks and so is there an idea to have that be more ongoing? We see in other states that for long-term services and supports, it's a more long-term benefit, but I know that Community Supports is meant to be a shorter-term solution and so just curious your thoughts on that?

00:40:11 — Bonnie Kwok — Slide 27

Thanks, Brianna. I'm going to pass it to my colleague, Joanna who leads the Community Supports program. So, I'm going to pass it to her to see if she might be able to answer that question better as I'm representing Transitional Care Services here.

00:40:28 — Brianna Moncada— Slide 27

Thank you.

00:40:30 — Bonnie Kwok — Slide 27

Joanna or Kristin?

00:40:37 — Anthony Davis — Slide 27 - 28

So, I can go ahead and take that question, my name is Anthony Davis, I'm the Community Supports Section Chief. So in regards to the 12 weeks, we did receive some comments and feedback from the field in regards to some of the service definitions that we are currently revising. So that is one of the comments and feedback that we did receive for the field. We are currently looking at that and we will take this back and we will work through this through our refinements that will be coming out at the beginning of the year.

00:41:14 — Brianna Moncada— Slide 28

Okay, thank you so much, really appreciate all of your guys' help and all the information today.

00:41:24 — Kristin Mendoza-Nguyen — Slide 28

Thank you, guys. The next question, this is on also on Community Supports, probably for Anthony and for Joanna. Susan LaPadula, when will the CalAIM 14 Community Supports be implemented for all MCPs, all counties statewide in California?

00:41:44 — Anthony Davis — Slide 28

I can go ahead and take that question as well. So MCPs are strongly encouraged to offer some or all of the pre-approved Community Supports and are expected to detail their Community Supports offerings and their model of care submission to DHCS. MCPS may add or remove Community Supports at defined

intervals every six months for addition. So, there's no requirement right now for them to have or to elect all 14 Community Supports. They may elect to offer a Community Supports every six months. And the goal and hope is that as we keep moving on with Community Supports that every MCP will elect to offer all 14 Community Supports.

00:42:36 — Kristin Mendoza-Nguyen — Slide 28

Thank you. There was one chat question on CBOs, from Loretta. Where can we get the list of CBOs for the state specifically in LA County, Ventura, and Inland Empire counties. This information is not available at this website at this time. Maybe a question, I don't know, for Anthony, Joanna, or potentially Bambi. Folks want to weigh in?

00:43:08 — Bambi Cisneros — Slide 28

Yeah, I don't know if there's a universal list of CBOs for the state, but we do have a listing I believe through PATH of certain CBOs that are participating in PATH. And so we can send as a follow-up to this call links to where we can share that information. But there's not a statewide list of CBOs per your question.

00:43:39 — Kristin Mendoza-Nguyen — Slide 28-29

Thank you. I'm not seeing any other questions on TCS, ECM, or Community Supports. So in the interest of time, because we do have other Q&A sessions, I know there were other questions that came in, we're going to proceed to the next section. So I'm going to turn it over to Stacy Nguyen, branch chief from the Managed Care Quality Monitoring Division who will be providing updates about all three of the LTC Carve-In All Plan Letters.

LTC Carve-In All Plan Letter Updates

00:44:06 — Stacy Nguyen — Slide 30

Thank you, Kristin. So, in September of this year, DHCS actually updated our Long-Term Care Carve-In All Plan Letters to clarify policy related to the managed long-term care members in skilled nursing facilities for subacute care and for ICF/DD homes. And those APL numbers are included here on the right side there, so 24-009, 10, and 11 respectively. The changes to the APLs largely apply across all of the Long-Term Care Carve-In populations. But as we go through these updates, we'll specify if an update is specific to just one long-term care benefit. I actually will now turn it over to Michael Jordan from the Capitated Rates and Development Division to kick us off with the payment and payment related updates.

00:45:02 — Micheal Jordan — Slide 31

Thanks, Stacy. And hello, everybody. So, regarding the per diem rate adjustments, Medi-Cal Fee-for-Service per diem rates, they do remain effective for all dates of service until an updated per diem rate is published by DHCS. MCPs must also implement a payment of the updated per diem rates on a prospective basis for all claims with applicable dates of service received on or after 30 working days of being notified by DHCS that the updated rates are published. So if additional amounts are owed retroactively to a network provider on any claims for applicable dates that were processed prior to MCPs implementing the updated per diem rates, then MCPs must pay any necessary retroactive

adjustments within 45 working days after being notified by DHCS that the updated rates are published. So now wanting to turn to timely payments and continuity of care. So payment processes including timely payments of claims requirements for network providers also do apply to out-of-network providers when those dates of service were under continuity of care. All right, I know that was a pretty short slide. I did want to transition this back to Stacy to discuss the new share of cost sections across all of the three LTC Carve-In APLs. So Stacy, back to you.

00:46:42 — Stacy Nguyen — Slide 32

Thanks, Michael. Next slide, please. So the APL language features a new share of cost section that provides some guidance on the share of cost policies and processes. Just want to remind everyone that there is a difference between share cost payments and balance billing a member. So balance billing typically refers to billing a patient for the difference between what the benefit covers and what a provider charges, which is strictly prohibited in Medi-Cal. This portion of the APL updated speaking specifically to receiving the share of costs for eligibility. So providers that collect payments are responsible for certifying share of costs in the Medi-Cal Eligibility Verification System or AEVS as we call it, to show that the member has paid their monthly share of costs amount owed. When a member has a share of costs, the provider would subtract that share of cost payment from the claim amount and submit that claim to the managed care plan so that they can pay the balance.

00:47:48 — Stacy Nguyen — Slide 32

We've also included some direction to providers for when a member uses share of cost funds to pay for necessary non-covered medical or remedial care services, supplies, equipment and drugs prescribed by a physician that aren't necessarily part of the plan of care authorized by the attending physician. So the provider would in these instances, subtract those amounts from a beneficiary's or from a member's share of cost and collect the remaining share of cost and not owed. And then the expenditures from the member's share of costs funds must be recorded on the record of non-covered services or on the DHS 6114 form. UB-04 for the long-term care section of the provider manual includes more information as well as a sample of this form to assist the providers through that process.

00:48:50 — Stacy Nguyen — Slide 33

Next slide. DHCS also revised language for the requirements surrounding the change of ownership or the CHOW process in the ICF/DD APL. Managed care plans do not need to receive that official pre-approval or assessment of suitability from the California Department of Public Health when contracting with the home provider undergoing a child. So managed care plans do need to ensure that the ICF/DD home providers undergoing a CHOW or a change of ownership provide verification that they are undergoing such a process prior to execution of the network provider agreement. I think the distinction is that it's not necessarily always going to be that assessment of suitability from CDPH. And DHCS will be providing further guidance concerning what qualifies as a verification to the managed care plans and the ICF/DD providers in our FAQ questions and those will be forthcoming.

00:50:00 — Stacy Nguyen — Slide 34-35

Next slide. Thank you. Given these updates, we are asking that managed care plans must submit and update their policies and procedures to ensure compliance with each respective APL. So the managed care plans would also be reviewing the network provider subcontractor agreements, including any

division of financial responsibility provisions and the managed care plan must submit all requirements in these APLs in their P&Ps to the Managed Care Operations Division, Oversight SharePoint submission portal. So just through the normal process that you would submit any P&P updates. And if there are any questions regarding that process in the P&P submission, please contact your DHCS contract manager with any questions and we'll work to address those. Next slide. DHCS has also updated the frequently asked questions across the different LTC benefit types for SNF, subacute care and ICF/DD populations to reflect the changes that were mentioned in the superseding APLs. These have been published to the web page as well, and so we included links here on the slide deck which will also be shared afterwards. And now I will turn it over to Kristin who will help lead our next Q&A session of the webinar.

LTC Carve-In APL Update: Q&A Session

00:51:35 — Kristin Mendoza-Nguyen — Slide 36-37

Great, thank you all. A couple of questions have come in. This question is both probably for Stacy and probably Michael. A question from Kimberly, from Momentum. "Who regulates the COHS for the per diem rates? Gold Coast Health Plan does not pay the retro rates on time."

00:52:52 — Stacy Nguyen — Slide 37

So I'm just looking at the question, Kimberly, here. And this is a great question because it does pertain to rates, but it is managed care plan compliance. And so I think if you're having specific concerns or issues here, I'm not sure Michael, if you guys have a shared inbox, if not, you can share that with the LTC transition inbox and they'll route it to their corporate party depending on the nature of the concern.

00:52:31 — Micheal Jordan — Slide 37

We can see it is a compliance question. As far as enforcement of that, I think it might be either a contract question if you want to go through the contract manager, that might make sense. If you do want to come through our certain inbox too, we can help route it. So I would say either a contract manager, if you want to send it into crddrates@dhcs.ca.gov, we can help you route it from there as well.

00:53:08 — Kristin Mendoza-Nguyen — Slide 37

Okay, great. Thank you, Michael. Another rates adjustment question in the box from Lisseth. "Our facility is pending retro rate adjustments for Medi-Cal for rates published February 16th, 2024. Is there someone I can contact?" They've called the phone line, but is there anyone else at the department that might be able to assist if there's an inbox or email?

00:53:45 — Stacy Nguyen — Slide 37

I think this will be the same as Kimberly's question. Let's see. If you could share any information or any communication that you've had with the plan to our LTC Transitions Inbox. We'll get that to the appropriate parties and work with the managed care plan to get more information.

00:54:16 — Kristin Mendoza-Nguyen — Slide 37

Okay. And then there's just a more general question from Lorenzo. "What is the process for notifying MCPs of a rate adjustment increase?"

00:54:33 — Stacy Nguyen — Slide 37

Michael, do you want to take that one?

00:54:42 — Micheal Jordan — Slide 37

Hey there, Stacy. I'm going through the chat, I'm trying to find this question. There it is. "What is the process for notifying MCPs of a rate adjustment increase?" That is a good question, we probably want to consult with our operations division colleagues. Is this question coming from the provider level or the plan level? Because I think we'd probably have to take that back, Lorenzo, do you have a shared email inbox you can contact? Otherwise, Stacy maybe either your inbox or my inbox, I'm not sure what you prefer?

00:55:35 — Bambi Cisneros — Slide 37

Yeah, it might be good to just use the centralized question, if we can just drop in the LTC Inbox. So the updates that was kind of flagged as the APL updates, which is DHCS, has now imposed timeframes by which plans need to do these retroactive adjustments. They're new and there's several different teams on the back end who is monitoring this, overall it is DHCS that oversees all of the Medi-Cal managed care plans, including the COHS. I believe this process originates from Fee-for-Service Rates Division, which they, they're not on this call, but we'll share the email inbox and we can follow up on specific plans. It looks like Gold Coast particularly. Thank you.

00:56:019 — Kristin Mendoza-Nguyen — Slide 37

Yeah, we just drop that in the chat from Becky Normile from our group. So, feel free contact that and we can help triage and support. There was one last question. This is specific, from Jeanette Potter. Are SNF/LTC facilities required to accept ICF rates if a patient and/or plan that doesn't want to discharge? I was under the impression they are required to pay AB 1629 rates.

00:57:08 — Micheal Jordan — Slide 37

So, it sounds like the question may be if a member is staying in a SNF and they don't want to discharge to an ICF facility or do they need to be paid the SNF rate or the ICF rate from the MCP is, how that how we may be understanding this? We do need to consult internally to get you the best response. So please, if you wouldn't mind emailing us at the ltctransition@dhcs.ca.gov inbox, I think we should be able to get a proper response to you shortly.

00:57:44 — Kristin Mendoza-Nguyen — Slide 37

Thank you, Michael. I'm not seeing any other new ones. So, with that, I'm going to transition to the next section of our presentation. So, I will hand it over to Kyna Kemp, who is the Chief in the Clinical Assurance Division to discuss the PASRR process.

PASRR and SNF WQIP Overview & Reminders

00:58:09 — Kyna Kemp — Slide 38-39

Thank you, Kristin. Now we'd like to take a few moments to discuss the PASRR, which is the Pre-admission Screening and Resident Review. So PASRR is a federally mandated program designed to prevent an individual's inappropriate nursing facility placement and retention. The PASRR process is required to ensure that individuals who may be admitted into a skilled nursing facility for long-term care

are primarily assessed for a serious mental illness, also known as SMI, and/or intellectual disability, developmental disability or related condition, which we refer to as ID/DD/RC. PASRR requirements are applicable for all Medicaid certified SNFs for admissions including SNF-A and SNF-B. The level one screening is used to identify if an individual has a diagnosed or suspected PASRR condition, which would either be an SMI, the ID/DD, or RC. If the level one screening is positive for a PASRR condition, then a level two evaluation may be required.

00:59:22 — Kyna Kemp — Slide 39

The level two evaluation is a PASRR-centered evaluation performed by the DHCS level II evaluations contractor or by a DDS Regional Center to confirm whether the individual has an SMI or an ID/DD/RC and assess the individual's nursing facility needs. The determination is the decision made by DHCS or DDS and is delivered to the provider and includes placement and treatment recommendations that are most appropriate for the individual. An SMI determination is made by DHCS and is available immediately in the PASRR online system. The ID/DD/RC determination is made and issued by the Department of Developmental Services Regional Centers and is uploaded into the PASRR online system. Next slide, please.

01:00:24 — Kyna Kemp — Slide 40

Since May of 2023, MCPs have reviewed the prior authorization request for SNF placement and confirmation of the PASRR Level 1 Screening. DHCS has provided flexibilities to help move members to appropriate levels of care. Importantly, hospitals cannot discharge the member until the MCP approves the prior authorization. PASRR requirements. So, for hospitals discharging to the SNF, the SNF must include the following information as a note in their prior authorization request. Confirmation of the PASRR Level 1 Screening was completed. And whether the Level 1 Screening resulted in a negative or positive for SMI, ID/DD or RC. And they should also include the PASRR case ID number, also known as the CID. Updated PASRR flexibilities. We have the PASRR information Notice 23-001, which allows MCPs to approve prior authorization for SNF placement as soon as a confirmation is received of a negative Level 1 Screening MCPS are only required to obtain and review PASRR documentation from providers for prior authorization review process when the Level 1 Screening is positive. And at this time, I will now hand it off to Kate.

01:02:00 — Kate Bravo — Slide 41

Thank you, Kyna. Hi everyone. My name is Kate Bravo. I'm the Health Program Specialist Lead for the Skilled Nursing Facility Workforce and Quality Incentive Program, also known as SNF WQIP. The SNF WQIP is a directed payment program that incentivizes SNF to improve quality of care, advance equity in health care outcomes, and invest in workforce. Assembly Bill 186 authorized DHCS to establish and implement the directed payment program for dates of service from January 1st, 2023 through December 31st, 2026. DHCS has three established SNF WQIP metric domains. First is Workforce Metrics, which include acuity adjusted staffing hour and staffing turnover. Second is Clinical Metrics which include Minimum Data Set (MDS) Clinical and Claims-Based Clinical metrics. Third is Equity Metrics, which include Medi-Cal Disproportionate Share, and MDS Racial and Ethnic Data Completeness.

01:03:12 — Kate Bravo — Slide 41-42

The minimum data set MDS measurement for the program is July 1st through June 30th each year, which is six months offset from the calendar year due to a lag of MDS. DHCS directs MCPs to calculate the number of SNF WQIP qualifying bed days and make per diem payments to facilities within 45 calendar days of receiving payment exhibits from DHCS or 30 days of receiving a provider clean claim, whichever is later. Next slide, please. Over the past several months, DHCS released various updates to the SNF WQIP through the technical program guide and through various policy letters. So first I want to highlight DHCS updated the MDS Data Completeness metric methodology using 150-day exclusion approach. This change is effective retroactively for program year one, which is 2023 of the SNF WQIP. For additional information, you may reference the SNF WQIP Policy Letter 24-002, which outlines the updated MDS data completeness methodology and provides technical clarification.

01:04:31 — Kate Bravo — Slide 42

I'll provide an update to the Claims-Based Clinical Measures. Originally these measures were to be calculated by managed care plans. However, due to an issue that managed care plans had in calculating MCAS LTC measures facility specific rates will be calculated by DHCS's contractor using claims warehouse data. Due to this change, the timeline for the SNF WQIP final payment report for PY1 2023 was pushed back to December 2024. DHCS issued a policy letter on this matter in September. And both policy letters are published to the SNF WQIP webpage. So if you would like more information on these updates, we encourage you to navigate to our webpage.

01:05:17 — Kate Bravo — Slide 43

Next slide, please. DHCS disseminated the final version of the PY2 2024 SNF WQIP Technical Program Guide to SNF stakeholders and published this guide to our web page as well. Public input was requested and comments were due to by November 1st, 2024. DHCS issued a Policy Letter relating to the “Percent of Residents Who Lose Too Much Weight, Long Stay.” This policy letter outlines the updated and shortened measurement for this measure. Performance during the shorter measurement will continue to have the same weight in the overall WQIP score. Again, please reference the policy letter relating to this update, which is 24-006, for more information.

01:06:12 — Kate Bravo — Slide 43

Let's see here. Next on September 25th, 2024, DHCS hosted a virtual SNF stakeholder webinar to discuss various updates and receive stakeholder input on the SNF WQIP, including potential changes for PY3 2025. Webinar materials were published to the SNF WQIP webpage. So if you would like to reference those meeting materials, we always publish them to our web page. Also, just wanted to mention interested stakeholders can receive relevant updates to the AB 186 programs by enrolling in the email listserv service. We have a link that we can go ahead and put in the chat, which will direct you to auto enroll if you'd like to receive updates and AB 186 programs, which include the Accountability Sanctions Program and WQIP and WSP. And just want to also mention DHCS welcomes feedback on the SNF WQIP, which can be sent to our program’s inbox at snfwqip@dhcs.ca.gov. Thank you so much for your time. And up next to speak is Bambi who will provide an update on other LTC policies.

Update & Reminders on Other LTC Policies

01:07:28 — Bambi Cisneros — Slide 44-45

Great, thank you so much, Kate. So, for our last topic here, we'll provide some updates and reminders and other relevant long-term care policies. And we can go on to the next slide. So, we wanted to take a moment here to discuss some policy areas that have been particularly challenging. And so, we'll cover the LTSS Liaison policy reminders, including promising practices that we have learned from the stakeholder landscape assessments, as well as a reminder on coordination of benefits and Medicare/Medi-Cal policy. So first I will turn it over to Stacy, who will cover the LTSS Liaison policy reminders and promising practices.

01:08:19 — Stacy Nguyen — Slide 46

Thank you, Bambi. So, the Long-Term Services and Supports Liaison serves as a single point of contact for service providers. The liaison is required to understand the full spectrum of Medi-Cal, long-term institutional care and in particular, assist providers with addressing claims and payment inquiries in a responsive manner. Care transitions among the LTSS provider community to support member needs. While the liaisons are primarily provider-facing, they do indirectly help ensure LTC members are accessing quality care. So, it's important to note that the LTSS Liaison will serve in different roles or departments depending on the managed care plan. Regardless of the department, the LTSS Liaisons work directly with providers to ensure needs of the LTC members are being met and they can help direct providers to the right contact and the right department, whether that's billing, claims, or support with authorizations.

01:09:28 — Stacy Nguyen — Slide 46-

And as a reminder, managed care plans must notify network LTC providers of changes to its LTSS Liaison assignment to ensure coordination and services offered to members as expeditious. And the managed care plans must also notify DHCS within five days of any change to the LTSS Liaison by updating the liaison listed in the SharePoint liaison directory and completing all required fields on the form as appropriate. So, I know that DHCS will on a quarterly basis go out and request those liaison updates, but it's also the plan's responsibility to update that as soon as they're aware of a change.

01:10:14 — Stacy Nguyen — Slide 47

Next slide please. This summer, managed care plans shared their rewards and challenges associated with their LTSS Liaison teams with us through the stakeholders landscape assessments. Long-term care providers shared that LTSS Liaisons can be exceptionally helpful when they're well versed in the benefits and unique needs of the LTC populations, when they have that internal support and capacity to resolve the provider issues, and when they do respond in a timely manner. We also wanted to share some promising practices shared by stakeholders during the landscape assessments on how the LTSS Liaisons can best support LTC providers. These include but aren't necessarily limited to identifying key internal contacts across different managed care plan departments so that the liaison knows who exactly who to go to. Developing a robust training plan, including potentially shadowing other LTSS Liaisons to ensure that if there are multiple liaisons, they're all resourceful across the MCP and can adequately provide tailored technical assistance.

01:11:30 — Stacy Nguyen — Slide 47

Also dedicating internal cross-departmental team to work through DHCS guidance, managed care plans where long-term care has been carved into managed care, shared that they have these cross-

departmental teams that include staff such as nursing care managers and medical authorization assistants who are experts in the LTSS space and have working relationships with the LTC providers and of course ensuring internal support from leadership. So managed care plans new to the Carve-In shared that support from their leadership helped with relationship building and understanding between the plans and the providers. Next slide. We'll touch on some coordination of benefits policy reminders.

01:12:23 — Stacy Nguyen — Slide 48

Next. Okay, perfect. Given that the majority of SNF residents are dual-eligible members, we wanted to take a moment to discuss the coordination of benefits across Medicare and Medi-Cal and provide a reminder of what Medicare and Medi-Cal are responsible for covering in the long-term care space. So, Medicare part A, which covers co-nursing facility care, offers the maximum benefit of 100 days in the nursing facility level B. There's no limit to the number of benefit periods a recipient may have if the Medicare criteria for the break between benefit periods is met. So, we've included a breakdown here of the Nursing Facility B, payer financial responsibilities. For the first 20 days, I apologize of a Skilled Nursing Facility stay. Medicare pays 100% of the approved amount. From days 21 to 100, Medicare pays all but the daily co-insurance while Medi-Cal managed care plans would pay the co-insurance. And then anything beyond a hundred days Medi-Cal is the primary payer.

01:13:35 — Stacy Nguyen — Slide 49

Next slide. For dual eligible populations, managed care Plans have been responsible for providing medically necessary Medi-Cal services that are not covered by Medicare as well as reimbursement to Medicare providers when the total Medicare costs do not exceed the allowable Fee-for-Service reimbursement rates. But we understand that and the reality in most cases is that Medi-Cal does not reimburse for most Medicare services, including deductibles and current co-insurance because the rate is higher than the Medi-Cal rate. However, we wanted to remind everyone that, or we wanted to flag the long-term care services exception that specified in APL 13-003 which indicates that Medi-Cal is responsible for paying the full co-insurance and deductible for long-term care services.

01:14:29 — Stacy Nguyen — Slide 49

Lastly, Medi-Cal is the payer of last resort, which means that Medi-Cal providers are required to bill Medicare and get the denial or confirmation that benefits are either not covered or exhausted. And stakeholders interested in learning more about the long-term care crossover claims policies can review both APL 13-003 and the provider manuals long-term care crossover claims section. That rounds us up for the coordination of benefits portion, I'll hand it back to Kristin who will help lead our final Q&A session before we wrap.

Updates & Reminders on Other LTC Policies Q&A Session

01:15:04 — Kristin Mendoza-Nguyen — Slide 50-51

Great. Thank you, Stacy. And thank you Kate and Kyna for your presentations today. We did not receive any questions in the chat from that last presentation section, but there were a couple of lingering questions that we didn't have time to get to in the other Q&As from the earlier periods. And so, I know one question that I'll start with as folks are still thinking about their questions for the newer content. It came in about share of cost. Stacy, this might be a question for you from the APL. But it came from

Anna, at the end of it. "Medi-Cal LTC claims are being paid without deducting the share of costs and this is creating overpayments. Do you have any information that you can offer on this issue?"

01:15:54 — Stacy Nguyen — Slide 51

Yeah, and I can only presume that Anna, you might be from a plan, and we can certainly take that back and touch bases its basis with the appropriate divisions within DHCS. But generally, it is the provider's responsibility to report that share costs collected and report it on the claim to subtract any share costs collected so that the managed care claim can be reported.

01:16:25 — Kristin Mendoza-Nguyen — Slide 51

Thanks. There's a question related to LTSS Liaisons in the chat from Doug, from Totally Kids. "The providers are not seeing any discipline penalties in regard to the absence of effective liaisons amongst most MCPs. Can DHCS implement penalties when the law is broken?" So, I think generally about oversight and moderate. Oh, go ahead.

01:16:53 — Stacy Nguyen — Slide 51

Yeah, no, thank you for that question or comment. We have been working with providers, providers and specific managed care plans too when we are made aware of any potential non-compliance issues. This is as part of the transition and as part of the Carve-In, I understand that many of the managed care plans are also working through this LTSS Liaison, making sure that they can all be stacked up as well. But we also understand the importance, and which is also why we share these best practices to make sure that the LTSS Liaisons that hold these roles are knowledgeable, are responsive. And when they are not, we do our best to try to hold the plans accountable to that as well. But a lot of that, I know that some providers have raised those to DHCS and we do work with our managed care plans. It's just not published, I guess.

01:17:59 — Kristin Mendoza-Nguyen — Slide 51

Okay. To piggyback on the LTSS Liaison question, Brianna had a question from Mom’s Meals in the chat. How do the roles of the TCS Care Managers and the LTSS Liaisons differ? I'm not sure if Dr. Bonnie is still on the line, but if both either Stacy or Bonnie, if you want to respond?

01:18:22 — Bonnie Kwok — Slide 51

Stacy, would you like me to take this one?

01:18:24 — Stacy Nguyen — Slide 51

Yeah, that would be great. Thank you, Bonnie.

01:18:26 — Bonnie Kwok — Slide 51

Okay, thanks. As we emphasized in the beginning of the presentation on Transitional Care Services care managers, TCS Care Managers are member-facing, whereas LTSS Liaisons are not member-facing, it's mostly provider-facing. And both the TCS Care Manager and LTSS Liaisons are not required to be credentialed or licensed but need to have the training and ability and the knowledge to support our members with LTSS needs. Additionally, in terms of contracting or designated by the plan, either both of

them can be contracted by the provider or the organization doesn't have to be within the plan themselves.

01:19:21 — Bonnie Kwok — Slide 51

And I think the most critical, again, is just having both of these care manager liaison roles, but really having this understanding of how to integrate and weave LTSS services for the members and knowing how and when to assess for eligibility and refer. And I believe it was Stacy who presented on the LTSS Liaison, but they really need to understand payment claims coverage resolutions and the overlap with TCS Care Managers is really knowing the coordination part in care management. I think there are more details, but I'll stop there. I know that there are some slides with APLs outlining specifically that role and I'm going to drop in the chat the TCS Care Manager's role under a Population Health Management Policy Guide if you would like to take a closer look. I hope that helps and I really love your questions, Brianna.

01:20:45 — Kristin Mendoza-Nguyen — Slide 51

Great, thank you guys.

00:00:00 — Stacy Nguyen — Slide 51

Another question regarding coordination of benefits from Jenny next in the chat. So, it says that many managed care plans are denying the Medicare co-insurance for the reason that Medicare paid more than the charges. This is what we just outlined as well as the exception too. So, in usual circumstances this would be the case, but with long-term care, which is why we wanted to highlight the relevance of APL 13-003, the managed care plans should be paying the full co-insurance and deductible for the applicable Medicare charges in accordance with APL 13-003. So, if the managed care plans continue to deny that Medicare co-insurance and not compliant with that APL, then Jenny, if you can just share some supporting documentation with us to the LTC transitions in the box so we can do some follow up as well.

01:21:49 — Kristin Mendoza-Nguyen — Slide 51

Great. Thank you, Stacy. That was going to be what I was going to go to next. Let's see, there's a question about a recording. A recording will be available, so that'll be on the website just for folks. There's also another question from a stakeholder named Barbara, Anthem Blue Cross, "Having issued COB for decent members with paying LTC claims and or showing member is active with them for medical health benefits, who can I connect with to address and help resolve these issues?"

01:22:29 — Stacy Nguyen — Slide 51

I think, Barbara, I think I might need a little bit more information as to what the specific concern is, but generally if you have a member specific concern, you can send an email again to that LTC Transition Inbox. But did you want to maybe clarify your question a little bit?

01:22:58 — Kristin Mendoza-Nguyen — Slide 51

If so, you can raise your hand and the team can unmute you.

01:23:10 — Stacy Nguyen — Slide 51

It sounds like it might be an eligibility issue. And so those are member-specific cases that we'll have to look up just to understand the eligibility history there and to see why that member might not be showing as active. You can send a secure email I think.

01:23:35 — Stephanie Conde— Slide 51

Hi, Stacy. This is Stephanie Conde from Managed Care Operations…

01:23:38 — Stacy Nguyen — Slide 51

I wasn't sure what inbox you wanted to use. Yeah.

01:23:42 — Stephanie Conde— Slide 51

If you could please, Barbara, please send an email in to the LTC inbox with your email and a little details describing what you're seeing and the department will send you a secure email to get the member level details. So again, just send us an email with a little more information along with your email address and then we will send level details to research further. Thank you.

01:24:08 — Kristin Mendoza-Nguyen — Slide 51

Thank you, Stephanie. Thanks, Stacy. I see another question similar to another one we received during the APL updates about pending retro-rate adjustments, but this one specifically for subacute from the Medi-Cal fee-for-service rates. I think similar as before, if you could send an email to LTC Transition Inbox, you can help triage that with the right division internally. There's a question from Mirna. "We have Medi-Cal members who would like to enroll to managed care, but they're denied stating that they have a share of cost." Stacy, you want to take that one?

01:24:50 — Stacy Nguyen — Slide 51

Sorry, I think I missed the question. Was this-

01:25:01 — Bambi Cisneros — Slide 51

Yeah, I think for these, Kristin, they're very specific situations. We would need the members CIN in order to research and really kind of pinpoint what issue occurred there. So, if you don't mind dropping your email address and then we'll respond back in kind with a secured email and provide us specific information that we'll look further into the issue. Thank you.

01:25:28 — Kristin Mendoza-Nguyen — Slide 51

Okay. Last thing. I know there's folks responding in the chat to one another, so I'm trying to be mindful to make sure we covered all of them. So, bear with me. I think we covered what we can and then if we haven't been able to cover them, we've directed you guys to the inbox. A team member will put another sort of chat with that email inbox in there just because I know the chat has a lot of things in there so you could easily find it. But with that I'm going to wrap us up and I'll let Bambi to help transition us and close us out for today.

Next Steps

01:26:07 — Bambi Cisneros — Slide 52-53

Okay, great. Thank you so much, Kristin. So, I think we can head over to next steps into the next slide. Thank you. So, before we conclude the webinar, we wanted to share some resources with you all. And so, on this slide you'll see a compilation of long-term care policy resources and these links include the up to date All Plan Letters that we walked through today, our resource guides for the managed care plans, FAQs and member information materials. So, we welcome you to take a look at those resources that are posted on our website. And then if we go onto the next slide. This will be our plug for our next webinar in the Long-Term Care Learning Series, which will occur next month. So, we are still looking to secure the date, but it will be in December. And this webinar will be to provide helpful tips and reminders for long-term care providers as they navigate managed care processes.

01:27:03 — Bambi Cisneros — Slide 54-55

And so we will place the link to register for this webinar as soon as we have that ready. And it's going to be posted on Long-Term Care Carve-In webpage that's linked on the slide. So please check back soon as we work on finalizing the December webinar. And so just really wanted to thank you all for your time today and we really thank you for the robust questions that were added to the chat. We are going to grab all of the questions and triage and route and respond accordingly. And again, if you have any additional questions that were not addressed during this webinar, we are leaving the long-term care transition email inbox here. So please email us at this email address. One thing of caution is if you are sending member-specific information, if you can just email us first and then we'll respond back via secured email. So, you can provide any member-specific details on that email that would be helpful. But again, thank you all for your time and have a great rest of your day. Thank you so much.