LTC Policy Update

Long-Term Care Learning Series

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

November 4, 2024

Meeting Management

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- Please use the “chat feature” to submit any questions you have for the presenters.
  - During Q&A discussion, participants can also be unmuted to provide additional context to a question submitted to the “chat”.
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  - For example: Kristin Mendoza-Nguyen – Aurrera Health Group

Agenda

Topics	Time
LTC Learning Series: Background and Overview	11:05 – 11:10 a.m.
Overview of CalAIM Policies Supporting LTC Members (PHM, Community Supports)	11:10 – 11:35 a.m.
Q&A	11:35 – 11:45 a.m.
Review of LTC All Plan Letter Updates	11:45 – 11:55 a.m.
Q&A	11:55 a.m. – 12:00 p.m.
PASRR and SNF WQIP Overview and Reminders	12:00 – 12:05 p.m.
Reminders on Other Relevant LTC Policies	12:05 – 12:15 p.m.
Q&A	12:15 – 12:25 p.m.
Next Steps and Closing	12:25 – 12:30 p.m.

LTC Learning Series
Background & Overview

DHCS

CalAIM Long-Term Care (LTC) Carve-In

Statewide institutional LTC in Medi-Cal Managed Care across specified LTC provider types started in 2023 and fully transitioned from Medi-Cal Fee-For-Service in 2024

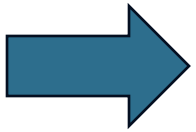
- On January 1, 2023, MCPs in all counties began covering the LTC benefit in **SNFs**.
  - All Plan Letter (APL) 24-009: SNF Carve-In
- On January 1, 2024, MCPs in all counties began covering the LTC benefit in the following:
  - **Subacute Care Facilities and Pediatric Subacute Care Facilities**
    - APL 24-010: Subacute Care Facilities Carve-In
  - **ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes**
    - APL 24-011: ICF/DD Carve-In
- On September 16, 2024, DHCS released updated APLs across all three of the LTC Carve-Ins.

LTC Stakeholder Landscape Assessment

- DHCS sought feedback from various stakeholders on their experience implementing the 2023 and 2024 CalAIM LTC Carve-In.
- This feedback informed the LTC Learning Series.

Stakeholder Landscape Assessment
Summer 2024

- 11 interviews with Managed Care Plan, LTC Provider, Regional Center, and LTC Ombudsman stakeholders across 28 organizations



LTC Learning Series
Fall/Winter 2024

- Session 1: Spotlight on Subacute Care Services (MCP focused)
- Session 2: LTC Policy Update
- Session 3: Managed Care Resources for LTC Providers (LTC Provider focused)

LTC Policy Update Session Learning Objectives

Today, we plan to cover:

- CalAIM policies that offer comprehensive services and supports for LTC members, including Population Health Management (PHM) including Transitional Care Services (TCS), Enhanced Care Management (ECM), and Community Supports
- Policy updates made to LTC Carve-In APLs: SNF 24-009, Subacute 24-010, and ICF/DD 24-011
- Updates on the SNF Workforce and Quality Incentive Program (WQIP) and reminders on Preadmission Screening and Resident Review (PASRR)
- Reminders on other relevant policies related to LTC, as identified during the Stakeholder Landscape Assessment

DHCS Staff Presenting LTC Policy Updates

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CalAIM Policies that Support Medi-Cal LTC Members

DHCS

Medi-Cal Members & MLTSS

DHCS' vision is that Medi-Cal members requiring Long-Term Services and Supports (LTSS) can remain in the least restrictive setting or level of care that meets their preferences, needs, and optimizes their quality of life.

Transitional Care Services (TCS) under Population Health Management (PHM)

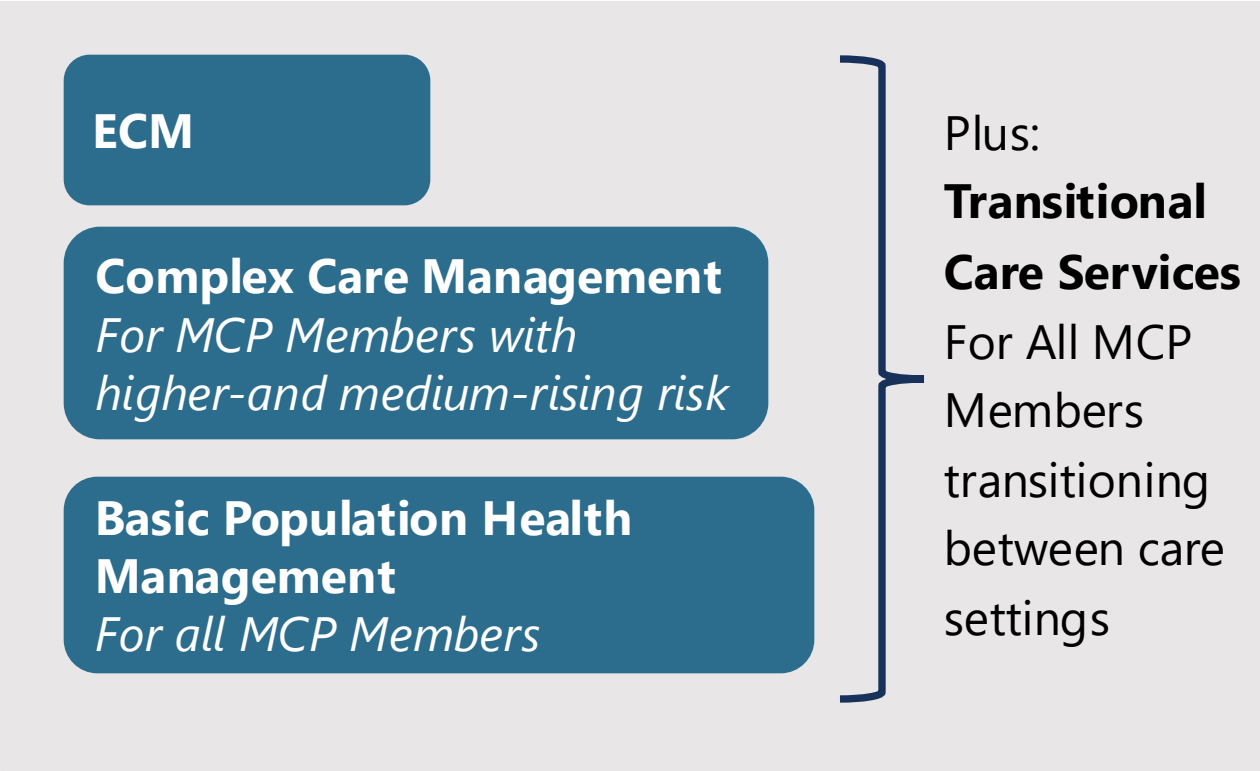
Enhanced Care Management (ECM)

Community Supports

CalAIM Care Management Continuum

Medi-Cal MCPs must have a broad range of programs and services to meet the needs of all members organized into the following three tiers:

- Enhanced Care Management (ECM) is for the **highest-need members** and **provides intensive coordination across the physical, behavioral, and dental health delivery systems**.
- Complex Care Management (CCM) is for members at **higher-and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.
- Basic Population Health Management (BPHM) is an array of programs and services for **all Medi-Cal MCP members**, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.



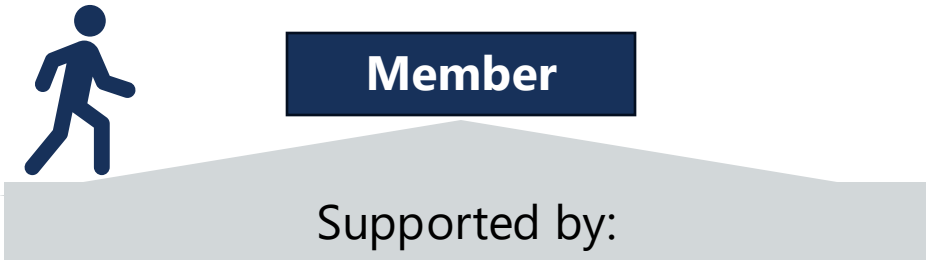
Aims of Transitional Care Services (TCS)

Care transitions are defined as a member transferring from one setting or level of care (LOC) to another.

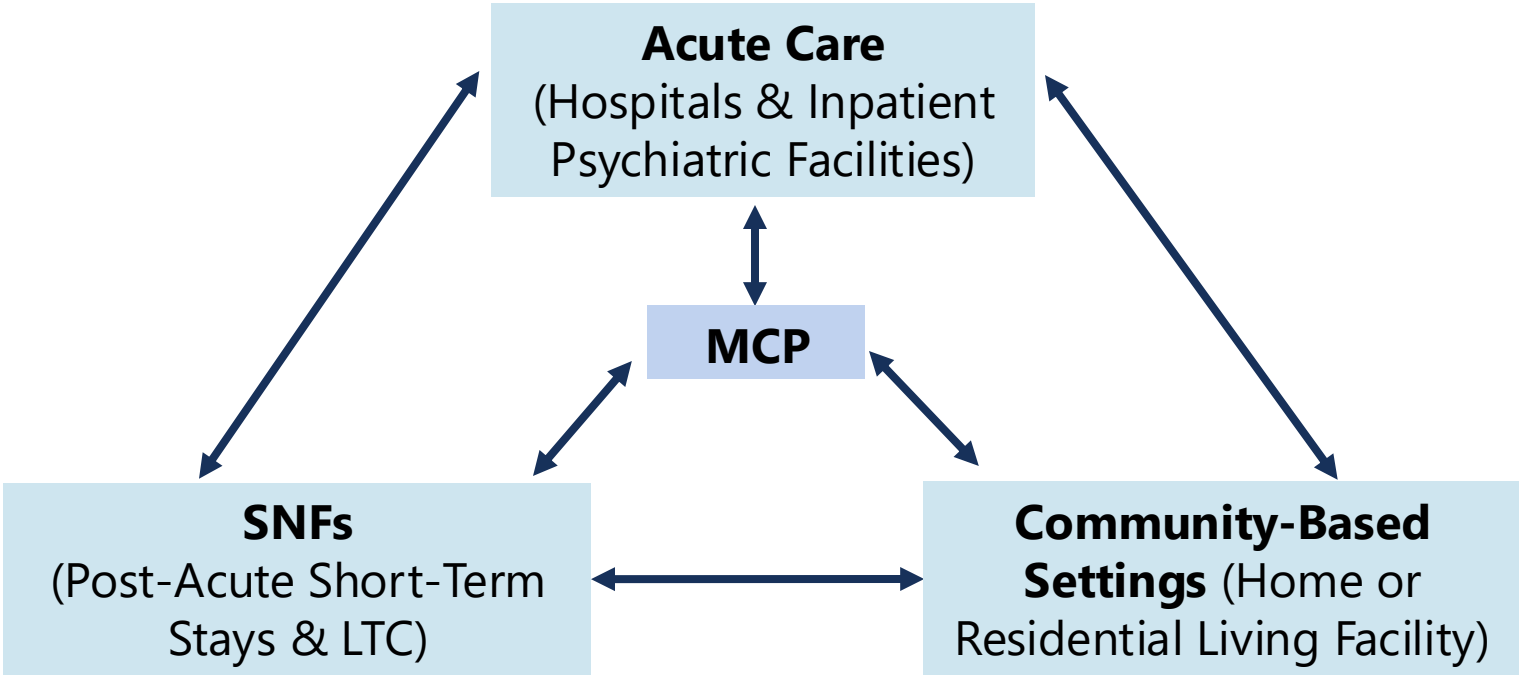
- Members can transition to the **least restrictive level of care that meets their needs and is aligned with their preferences** in a timely manner without interruptions in care.
- Members receive timely **needed support and coordination to have a safe and secure transition** with the least burden on the Member as possible.
- Members continue to have the **needed support and connections to services that make them successful in their new environment.**

Transitional Care Services (TCS)

- **MCPs are required to deliver TCS** to ensure that all their members are supported throughout their transition.
- For members with **LTSS needs**, that includes that the MCP assign a single point of contact **TCS Care Manager.**
- **MCPs, hospitals, and SNFs are jointly accountable** to ensure successful transitions of care for members with LTSS needs.



Strong relationships and shared accountability among entities at all levels of care and the MCP:



TCS Requirements for All Members

Beginning in 2024, MCPs are required to implement TCS for **all Members** to ensure they are supported from discharge planning until they have been successfully connected to all needed services and supports.

General MCP Requirements for All Members

- Know when a Member is **admitted/discharged/transferred** (A/D/T)
- Ensure each Member is **evaluated for all care settings** appropriate to their needs
- Ensure the completion of the discharging facility's **discharge planning process**
- Ensure all Members being discharged have a **primary care provider** who can provide follow up care
- Ensure **referrals** to Community Supports, ECM, and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community Based Services (HCBS) programs
- Ensure **timely prior authorizations**

TCS Requirements for All Members

Beginning in 2024, MCPs are required to implement TCS for **all Members** to ensure they are supported from discharge planning until they have been successfully connected to all needed services and supports.

- TCS for both high- and lower-risk members focuses on **ensuring necessary follow up (e.g., ambulatory or PCP visits) are completed**, for necessary post-discharge care and services, including medication reconciliation.

Difference Between TCS for High vs. Lower-Risk Members

- For high-risk members, MCP must ensure the Member has a **single point of contact** who proactively support members for the duration of the transition.
- For lower-risk members MCPs must ensure a **dedicated team/phone number** will be available to members to support them as needed.

Ensuring that Members transition to the least restrictive level of care that meets their needs and aligns with their preferences is a cornerstone of TCS.

TCS: Care Manager

The TCS Care Manager is responsible for ensuring collaboration, communication, and coordination with members and their family or caregiver, discharging facility, PCP, and any other identified follow up provider to facilitate safe and successful transitions.

- MCPs must identify a TCS Care Manager, to serve as the **single point of contact** responsible for providing **longitudinal support** and ensuring the completion of all TCS across **all settings and delivery systems**.
- MCPs must **communicate** with the **responsible TCS Care Manager** and the **discharging facility** in a timely manner so the care manager can coordinate with the discharging facility on discharge planning and support access to available services.
- Care manager is responsible **for coordinating** and verifying that **high-risk members receive all appropriate TCS**, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations.

TCS: Care Manager Responsibilities

The care manager is the single point of contact responsible **for coordinating** and verifying that **high-risk members receive all appropriate TCS**, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations.

- Best practice *(not required)* is for the care manager to work with the facility to ensure that the care manager's name and contact information are integrated into the discharge documents.

Care managers must:

- **Identify** members who may be **newly eligible** for **ongoing** care management and/or Community Supports and make appropriate referrals.
- **Receive** and **review** a copy of the discharging facility's provided instructions. Upon discharge, care manager must review the discharge instructions **with the member** and ensure the member can provide input and have questions answered.
- Ensure **all follow-up providers** have **access** to the needed clinical information from the discharging facility, including the discharge summary.

TCS: Discharge Communications

MCPs are accountable for providing all TCS in collaboration and partnership with discharging facilities to ensure the discharge process is aligned with the member's care plan goals.

- MCPs must ensure discharging facilities complete a discharge planning process that:
  - Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.
  - Ensures discharging facilities are coordinating care with the member's designated family caregiver(s), including the notification of the member's discharge or transfer to another facility and with any post-discharge providers.

More information regarding Transitional Care Services' policies and requirements for members with LTSS needs can be found in the PHM Policy Guide.

DHCS recently published the TCS for Members with LTSS Needs Technical Assistance Resource for MCPs highlighting promising practices and range of different LTSS programs and resources to support members with LTSS needs undergoing transitions of care.

ECM & Community Supports

- Enhanced Care Management (ECM) and Community Supports are foundational parts of Medi-Cal's **extension beyond traditional hospitals and health care settings into communities**.
- ECM and Community Supports are both administered by Medi-Cal Managed Care Plans to MCP members, in partnership with community-based providers.

What Is Enhanced Care Management (ECM)?

ECM is a statewide Medi-Cal MCP benefit to support comprehensive care management for Members with complex needs provided primarily through in-person interactions with Members where they live, seek care, or prefer to access services.

Medi-Cal MCP Care Management Continuum

ECM is the **highest tier of care management** for MCP Members.

- ECM is organized by Populations of Focus (POFs), each with unique eligibility criteria and service requirements. There are two POFs for those with LTC needs:
  - **Adults Living in the Community and At Risk for LTC Institutionalization**
  - **Adult Nursing Facility Residents Transitioning to the Community**
- The aim of ECM for both populations is to enhance their ability to live independently and safely and remain connected to what matters most to them.

Spotlight on ECM for LTC Populations

In June 2024, DHCS released the **ECM for POF Spotlight.**

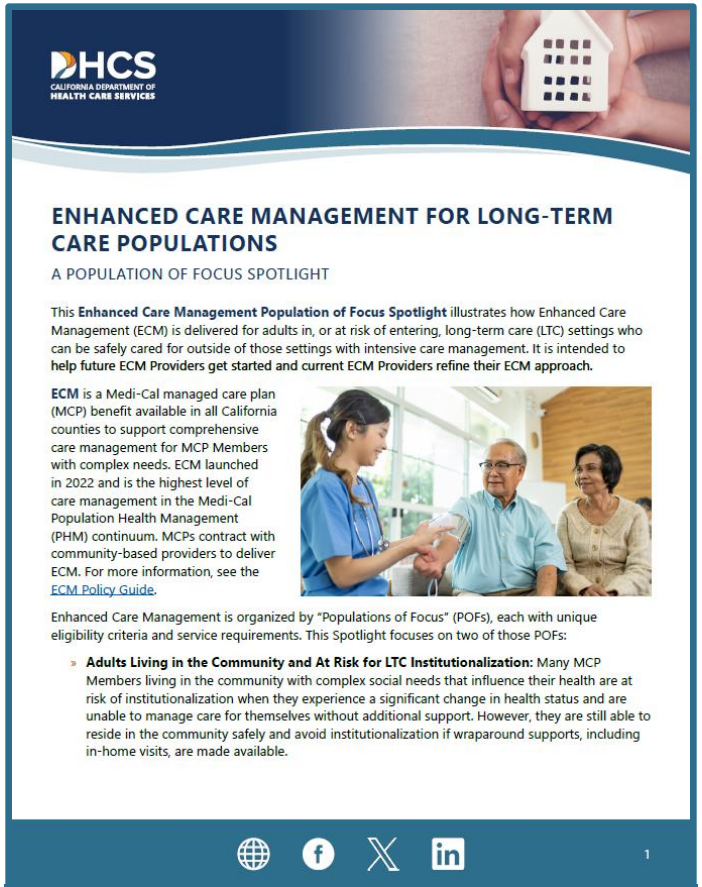
- Highlights key DHCS policies and resources on serving individuals in, or at risk of entering, institutional LTC in ECM settings, including, a crosswalk of how members with long-term services and supports (LTSS) needs receive care management support .
- Contains member vignettes that illustrate how to implement ECM for these POFs:

Older adult living with Parkinson's disease who wish to remain at home

Older adult temporarily residing in a skilled nursing facility and recovering from a stroke

- Explains how Community Supports and Transitional Care Services can be integrated to best serve members and their caregivers.

This is the third in a **series of Spotlights** on how providers can deliver ECM models tailored to the needs of different POFs.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ENHANCED CARE MANAGEMENT FOR LONG-TERM CARE POPULATIONS

A POPULATION OF FOCUS SPOTLIGHT

This **Enhanced Care Management Population of Focus Spotlight** illustrates how Enhanced Care Management (ECM) is delivered for adults in, or at risk of entering, long-term care (LTC) settings who can be safely cared for outside of those settings with intensive care management. It is intended to **help future ECM Providers get started and current ECM Providers refine their ECM approach.**

ECM is a Medi-Cal managed care plan (MCP) benefit available in all California counties to support comprehensive care management for MCP Members with complex needs. ECM launched in 2022 and is the highest level of care management in the Medi-Cal Population Health Management (PHM) continuum. MCPs contract with community-based providers to deliver ECM. For more information, see the ECM Policy Guide.

Enhanced Care Management is organized by "Populations of Focus" (POFs), each with unique eligibility criteria and service requirements. This Spotlight focuses on two of those POFs:

- **Adults Living in the Community and At Risk for LTC Institutionalization:** Many MCP Members living in the community with complex social needs that influence their health are at risk of institutionalization when they experience a significant change in health status and are unable to manage care for themselves without additional support. However, they are still able to reside in the community safely and avoid institutionalization if wraparound supports, including in-home visits, are made available.

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To learn more, please visit the ECM and Community Supports webpage.

CalAIM Community Supports

DHCS has pre-approved medically appropriate and cost-effective Community Supports that MCPs are encouraged but not required to offer as substitutes for utilization of other services or settings.

- Community Supports are administered by MCPs but delivered by community-based providers who are experienced and skilled in serving the members who need each service.
- There are two Community Supports that are most applicable to LTC members:
  - Facility Transition/Diversion to Assisted Living Facilities
  - Community Transition Services/Nursing Facilities Transition to a Home

See Community Supports Elections Spreadsheet on DHCS website for MCP selections statewide.

Who is Eligible for Community Supports?

Members, their caregivers, and providers can contact MCPs directly to learn which Community Supports are offered that members may be eligible to receive and the eligibility requirements for each service.

- Each Community Support has specific eligibility criteria linked to each service.
- Enrollees in Medi-Cal Managed Care may be eligible for Community Supports, which are also voluntary for Members to accept.
- There is a mix of what Community Supports are available with each plan and each county.
- Community Supports are available to a wide range of members, including those with high needs and those who are enrolled in ECM.

MCP members do <u>not</u> need to be enrolled in ECM to receive Community Supports.

How Do Members Access Community Supports?

Direct contact from a health plan and/or Community Supports provider	Medi-Cal health plans are responsible for regularly identifying members who may benefit from Community Supports and who meet the criteria for the program. Once a member is identified, the health plan and/or their assigned Community Supports provider will contact them to discuss Community Supports.
Referral from a health and social services provider	If a member has not yet been identified by the Medi-Cal health plan as eligible for Community Supports, but appears to meet the requirements, their provider can submit a referral to the member's health plan. The health plan is required to have a referral process that is available for health and social service providers.
Self-referral or information inquiry	A member or the member's family can contact their Medi-Cal health plan to see if they qualify for Community Supports. Members can contact their health plan by calling the number on the back of their insurance card.

NF Transition Community Supports

Community Support Service	Brief Service Description
Nursing Facility Transition/Diversion to Assisted Living Facilities (ALFs)	Facilitates a Member's transition into an ALF, RCFE or ARF for Members who are currently receiving nursing facility level of care (LOC) or who meet the criteria to receive nursing facility LOC. Services include: 1. Time-limited **transitional coordination** that enables a Member to establish residence in an ALF, RCFE or ARF. 2. Ongoing assisted living expenses (except room and board) that include **wrap-around care** (e.g., assistance with Activities of Daily Living).
Community Transition Services/Nursing Facility Transition to a Home	Facilitates a Member's transition from a licensed facility **to a private residence** where the Member is directly responsible for his or her own living expenses. Services include: 1. Time-limited **transitional coordination** that enables a Member to transition into a private residence **2. Non-recurring set up expenses** (e.g., security deposits, set-up fees for utilities, pest eradication)

DHCS anticipates releasing refined service definitions for both Community Supports to clarify allowable settings and services and support uptake of the services.

Nursing Facility Transition/Diversion to Assisted Living Facilities: Eligibility Criteria

Nursing Facility Transition

- Resided 60+ days in a nursing facility;
- Willing to living in an assisted living facility as an alternate to a Nursing Facility; and
- Able to safely reside in an assisted living facility with appropriate and cost-effective supports.

Nursing Facility Diversion

- Interested in remaining in the community;
- Willing and able to safely reside in an assisted living facility with appropriate and cost-effective supports and services; and
- Receiving medically necessary nursing facility level of care (LOC) or meet minimum criteria to receive nursing facility services in lieu of going into a facility, is choosing to remain the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

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

DHCS

Question Logistics

- DHCS will now provide time for Q&A on CalAIM PHM, TCS, ECM, & Community Supports with today's stakeholder audience.

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

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

LTC Carve-In All Plan Letter Updates

DHCS

LTC Carve-In All Plan Letters Updates

DHCS has updated LTC Carve-In All Plan Letters to clarify policy related to LTC members in Skilled Nursing Facilities (24-009), Subacute Care Facilities (24-010), and ICF/DD Homes (24-011).

- DHCS has published superseding LTC All Plan Letters (APL) to clarify policy related to LTC Medi-Cal members receiving care through Managed Care Plans.
- Changes to the APLs largely apply across all LTC Carve-In Populations (SNF, Subacute, and ICF/DD)
- DHCS has updated LTC APLs in the following categories which will be reviewed during today's session:
  - Per diem rate adjustment processes
  - Share of Cost (SOC)
  - ICF/DD Change of Ownership processes
  - Clarifications for Managed Care Plan compliance requirements and processes

New LTC Carve-In APLs

SNF: APL 24-009 supersedes APL 23-004

Subacute: APL 24-010 supersedes APL 23-027

ICF/DD: APL 24-011 supersedes APL 23-023

APL: Per Diem Rate Adjustments & Timely Payment Under Continuity of Care

Per Diem Rate Adjustments

- Medi-Cal FFS per diem rates remain effective for all dates of service until an updated per diem rate is published by DHCS.
- MCPs must implement payment of the updated per diem rate on a prospective basis for all claims with applicable dates of services, received on or after **30 Working Days** of being notified by DHCS that the updated rates are published.
- 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.

Timely Payment Under Continuity of Care

- Payment processes including timely payment of claims requirements for Network Providers **also apply to Out-of-Network Providers** when those dates of service were under Continuity of Care.

APL: Share of Cost

- MCPs must process claims submitted by LTC providers consistent with the Share of Cost (SOC) Medi-Cal guidelines in the Medi-Cal LTC Provider Manual.
- LTC providers are responsible for collecting SOC payments, if the Medi-Cal eligibility verification system indicates a member has a SOC.
- LTC providers are also responsible for reporting the collection of SOC to MCPs on claims submitted for those members.
- Pursuant to *Johnson v. Rank*, a member may spend part of their Share of Cost on medically necessary services, supplies, or equipment not covered by Medi-Cal.
- The LTC provider will need to subtract those amounts from a beneficiary's SOC and collect the remaining SOC amount owed.
- The expenditures from the member's SOC funds must be recorded on the Record of Non-Covered Services (DHS 6114 form).

Please refer to the Share of Cost: UB-04 for LTC section of the Provider Manual for more SOC information including a sample completed DHS 6114 form.

APL: ICF/DD Change of Ownership (CHOW)

- Guidance regarding the information MCPs need to obtain when contracting with an ICF/DD Home that is undergoing a CHOW has been revised.
- MCPs must ensure ICF/DD Home providers undergoing a change of ownership **provide verification they are undergoing such a process** prior to the execution of a Network Provider Agreement. MCPs may accept either of the following documents as sufficient verification that the ICF/DD Home is undergoing a change of ownership for the purposes of contracting with an MCP:
  - A copy of the signed management agreement between the incoming and previous owner
  - A copy of the application approval letter provided by the California Department of Public Health

Next Steps: MCP P&P Submission

- **Given updates to LTC policy in APL 24-009, APL 24-010, and APL 24-011, MCPs must update and submit their Policies and Procedures (P&Ps) to ensure compliance with each APL.**
  - MCPs should review their Network Provider/Subcontract Agreements including Division of Financial Responsibility provisions.
  - MCPs P&Ps must include all requirements in these APLs to the Managed Care Operations Division (MCOD) Oversight SharePoint Submission Portal.
- MCP compliance officers should contact their DHCS Contract Manager with any questions.

Updated LTC Resources

DHCS is updating LTC Resources across SNF, Subacute, and ICF/DD populations that reflect changes in the superseding APLs 24-009, 24-010, and 24-011.

Skilled Nursing Facilities

- CalAIM LTC Carve-In Transition Webpage

Subacute Care Facilities

- Subacute Care Facility LTC Carve-In Webpage

ICF/DD Homes

- ICF/DD LTC Carve-In Webpage

LTC Carve-In APL Updates: Q&A

DHCS

Question Logistics

- DHCS will provide time for Q&A on the LTC APL Updates with today's Office Hours stakeholder audience.

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

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

PASRR and SNF WQIP Overview & Reminders

DHCS

PASRR Process

The Preadmission Screening and Resident Review (PASRR) is a process required by federal law to prevent an individual's inappropriate nursing facility admission and retention.

- The PASRR process is required to ensure that individuals who may be admitted into a nursing facility for a long-term stay are preliminarily assessed for serious mental illness (SMI) and/or intellectual disability/ developmental disability (ID/DD) or related condition (RC).
- PASRR requirements are applicable for all Medicaid-certified nursing facilities for all admissions including NF-A and NF-B.

Level 1 Screening

Used to identify if an individual has a PASRR condition (SMI, ID/DD/RC). If the Level 1 Screening is **positive** for a PASRR condition, then a Level 2 Evaluation is required.

Level 2 Evaluation

A person-centered evaluation performed by DHCS or DDS that confirms whether the individual has an SMI, ID/DD/RC and assesses the individual's nursing facility service needs.

Determination

An SMI Determination made by DHCS, available online, or an ID/DD/RC Determination made and issued by DDS.

PASRR Requirements and Flexibilities

Since May 2023, MCPs have reviewed prior authorization requests for SNF placement and confirmation of PASRR Process. DHCS has provided flexibilities to help move members to the appropriate care level.

Hospitals cannot discharge the member until the MCP approves the prior authorization.

PASRR Requirements

- Hospitals discharging a member to a SNF must include the following information as a note in the prior authorization request:
  - Confirmation that the PASRR Level 1 Screening was completed
  - Whether the Level 1 Screening resulted in a negative or positive for SMI, ID/DD, or RC
  - The PASRR Case ID (CID)

Updated PASRR Flexibilities

- PASRR Information Notice 23-001 allows MCPs to **approve prior authorization** for SNF placement **as soon as confirmation is received** of a **negative** Level 1 Screening
- MCPs are only required to obtain/review PASRR documentation from providers for prior authorization review process when a Level 1 Screening is **positive**

SNF WQIP Overview

The SNF Workforce & Quality Incentive Program (WQIP) is a directed payment program that incentivizes SNF providers to improve quality of care, advance equity in healthcare outcomes, and invest in workforce.

- Assembly Bill (AB) 186 authorized DHCS to establish and implement the directed payment program for dates of service January 1, 2023 and December 31, 2026.

Metric Domains

- DHCS has established 3 SNF WQIP Metric Domains:
  - Workforce Metrics (Acuity-Adjusted Staffing Hour Metrics; Staffing Turnover Metric)
  - Clinical Metrics (Minimum Data Set Clinical Metrics; Claims-Based Clinical Metrics)
  - Equity Metrics (Medi-Cal Disproportionate Share; MDS Racial and Ethnic Data Completeness)
- The Minimum Data Set (MDS) measurement period for the program period is July 1 – June 30 each year (i.e. 6 months offset from calendar year) due to data lag of MDS.

Payment Timeline

- DHCS directs MCPs to calculate 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).

SNF WQIP Updates

This fall, DHCS released updates to SNF WQIP through policy letters and program guides.

MDS Data Completeness Updated Methodology and Clarification

- DHCS updated methodology and technical clarification for the SNF WQIP using a 150-day exclusion approach, effective retroactive for PY1.
- See SNF WQIP PL 24-002 MDS Data Completeness Updated Methodology and Clarification policy letter published on the SNF WQIP webpage.

Claims Based Clinical Measures

- Originally, these measures were to be calculated by managed care plans
- However, due to issue with managed care plans had calculating Managed Care Accountability Sets (MCAS) Long-Term Care (LTC) measures, facility-specific rates will be calculated by DHCS's contractor using claims warehouse data.
- This pushes back the timeline for the Final Payment PY1 (2023) SNF WQIP Report to December 2024.
- SNF WQIP PL 24-003 Claims-Based Clinical Metrics Update policy letter published on September 6, 2024 on the SNF WQIP webpage.

Stakeholders interested in learning more about SNF WQIP and related guidance and updates can visit the SNF WQIP Webpage.

SNF WQIP Updates

This fall, DHCS released updates to SNF WQIP through policy letters and program guides.

PY2 Updates

- The PY2 (2024) SNF WQIP Technical Program Guide was published September 2024.
- PY2 Percent of *Residents Who Lose Too Much Weight, Long Stay*: DHCS consulted SNF stakeholders regarding the measure and has updated the measurement period to start 30 days after notice was sent to stakeholders, March 1, 2024 – June 30, 2024. See: SNF WQIP PL24-006 SNF WQIP Weight Loss Measure Update for PY2 (2024) for more information.

PY3 Updates & Potential Changes

- Information on various measure updates including some potential changes included in September 25, 2024, SNF WQIP Webinar materials to be posted on the webpage.
- Please provide feedback on potential changes for PY3 to the SNF WQIP Inbox at SNFWQIP@dhcs.ca.gov.

Stakeholders interested in learning more about SNF WQIP and related guidance and updates can visit the SNF WQIP Webpage.

Updates & Reminders on Other LTC Policies

Updates & Reminders on Other LTC Policies

To support LTC providers and MCPs continue developing working relationships, we are covering:

Long-Term Supports & Services (LTSS) Liaison Policy Reminders & Promising Practices

Reminder of Coordination of Benefits: Medicare & Medi-Cal LTC Policy

- During the Stakeholder Landscape Assessment, stakeholders offered valuable insights and best practices regarding the LTSS Liaison role, shedding light on its significant impact.
- Additionally, challenges have emerged in ensuring the accurate processing of crossover claims for dual members receiving LTC services.

LTSS Liaison Policy Reminders

The LTSS Liaison serves as a single point of contact for service providers and is required to understand the full spectrum of Medi-Cal long-term institutional care.

- The LTSS Liaison assists service providers with:
  - Addressing claims and payment inquiries in a responsive manner
  - Care transitions among the LTSS provider community to support members' needs
- It is important to note that the LTSS Liaison will serve in different roles or departments depending on the MCP.
- MCPs must notify Network LTC providers of changes to LTSS Liaison assignment expeditiously to ensure coordination and services offered to members.
- MCPs must also notify DHCS within five days of the change by updating the information in the SharePoint Liaison Directory.

LTSS Liaison Takeaways from Stakeholder Landscape Assessment

The LTSS Liaison role is rewarding but also challenging.

- LTC Providers stated that LTSS Liaisons can be exceptionally helpful when they are well-versed in the benefits and populations, have the internal support and capacity to help, and are responsive

Promising practices identified from the Stakeholder Landscape Assessment:

- Developing a LTSS Liaison team so that LTC providers have one team or person that they are receiving information from and working with
- Ensuring the LTSS Liaison has the capacity to help LTC providers by:
  - Identifying key internal contacts across different MCP departments
  - Developing a robust training plan (including shadowing other LTSS Liaisons) to ensure LTSS Liaisons are resourceful across the MCP and can adequately provide tailored technical assistance to LTC providers
  - Dedicating an internal cross-departmental team to work through the DHCS guidance
  - Ensuring internal support from leadership

Coordination of Benefits: Medicare & Medi-Cal Policy Reminder

Medicare Part A (inpatient care, critical access hospitals, and SNFs) benefits are reimbursed according to the following criteria.

- Medicare Part A offers a maximum benefit period of 100 days in a Nursing Facility Level B (NF-B).
- There is no limit to the number of benefit periods a recipient may have if the Medicare criteria for the break between benefit periods is met (released from a facility for 60 consecutive days)

First 20 Days
Medicare pays 100% of the approved amount

Days 21 to 100
Medicare pays all but daily coinsurance; Medi-Cal (MCP) pays the coinsurance

Beyond 100 Days
Medi-Cal (MCP) is the payer

Coordination of Benefits: Medicare & Medi-Cal Policy Reminder

- For dually eligible populations, MCPs have always been responsible for:
  - Providing medically necessary care that is not covered by Medicare, and
  - Reimbursement to Medicare providers when total Medicare costs, including deductibles and coinsurance, do not exceed the Medi-Cal allowable FFS reimbursement rates
- The reality in most cases is that Medi-Cal does not reimburse for most Medicare services, including deductibles and coinsurance, because the Medicare rate is typically higher than the Medi-Cal rate
  - **Long-term Care Services Exception:** Per APL 13-003, Medi-Cal is responsible for paying the full coinsurance and deductible for LTC services.
- Since Medi-Cal is the payer of last resort, Medi-Cal providers are required to bill Medicare and obtain a denial notice or confirmation that Medicare benefits have been exhausted or are not covered.

Stakeholders can learn more about LTC Crossover Claims Policy in APL 13-003 and the Provider Manual LTC Crossover Claims section.

Updates & Reminders on Other LTC Policies Q&A

DHCS

Question Logistics

- DHCS will provide time for Q&A on PASRR, SNF WQIP, as well as MCP LTSS Liaison and Coordination of Benefits policies with today's Office Hours stakeholder audience.

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

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

Next Steps

LTC Policy Resources

APLs:

- APL 24-009: SNF Carve-In (Supersedes APL 23-004)
- APL 24-010: Subacute Carve-In (Supersedes APL 23-023)
- APL 24-011: ICF/DD Carve-In (Supersedes APL 23-023)

Resources:

- SNF and Subacute Resources for MCPs
- ICF/DD Resource Guide

FAQs:

- SNF Carve-In
- ICF/DD Carve-In
- Subacute Carve-In

Information for Members

- SNF Carve-In Fact Sheet
- ICF/DD Carve-In Member Information
- Subacute Carve-In Member Information

Upcoming Webinar

- **LTC Learning Series: Managed Care Resources for LTC Providers** (December, date TBD)
  - This webinar will provide helpful tips and reminders for LTC providers as they navigate managed care processes.

Additional webinar details, including registration links, will be published on the LTC Carve-In websites as soon as they are available.

Thank you!

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

DHCS