CALTCM
California Association of Long Term Care Medicine

# Webinar Series

**March 27, 2023**

*Promoting quality patient care through medical leadership and education*

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## Webinar Planning Committee

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LMG
21st ANNUAL CONFERENCE
Leadership & Management in Geriatrics
UNLOCK YOUR LEADERSHIP POTENTIAL
August 3 - 4 & 11, 2023
One program, three days.
Step 1 Register for LMG
LIVE Virtual Event
17.5 Hours of CME/CMD/CEU's* See website for details.
www.caltcm.org
Day 1: Thursday August 3
Day 2: Friday August 4
Day 3: Friday August 11

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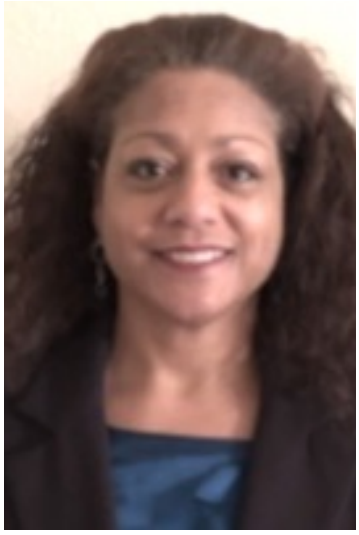

## Webinar Faculty

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March 27, 2023

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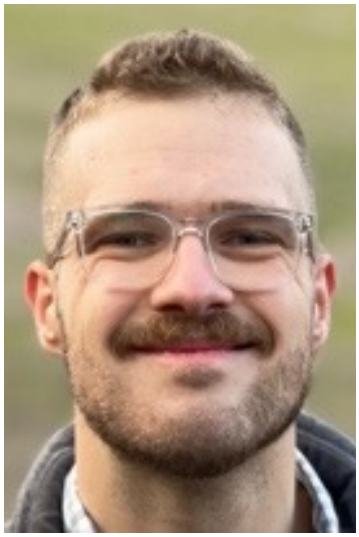

## Webinar Faculty

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## Webinar Faculty

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March 27, 2023

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## Webinar Faculty

**Laura Miller, MD**

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## Webinar Moderator

**Karl E. Steinberg, MD, CMD, HMDC, HEC-C**

AMDA & CALTCM, Past President

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## CalAIM & SNF Workforce & Quality Incentive Program (WQIP)

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Medical Consultant, Quality & Population Health Management Division

Alek Klimek
Chief, Fee-For-Service Rates Development Division

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

March 27, 2023

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# California Advancing and Innovating Medi-Cal (CalAIM)

**CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The goals of CalAIM include:**

- Implement a whole-person care approach and address social drivers of health.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation.
- Create a consistent, efficient, and seamless Medi-Cal system.

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## **CalAIM Components** that Impact Seniors & Persons with Disabilities (SPDs) and Dual Eligible Members live January 1, 2023

1. **Integrated care for dual eligible Medi-Cal and Medicare Members**
   - Statewide mandatory Medi-Cal managed care for dual eligibles
   - Aligned Enrollment Dual Special Needs Plans (D-SNPs) launch in 12 counties; Cal MediConnect (CMC) ends and Exclusively Aligned Enrollment (EAE) D-SNPs launch in the Coordinated Care Initiative (CCI) counties.
2. **Statewide carve in of long-term care (LTC) into managed care (in counties or plans that do not already include LTC)**
3. **Population Health Management (PHM) Program go-live in the Medi-Cal Managed Care Delivery System**

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## PHM Program Overview

**DHCS established a cohesive, statewide approach to PHM through which MCPs and their networks and partners must be responsive to individual member needs within the communities they serve, including physical health, behavioral health, and SDOH needs, while also working within a common framework and set of expectations.**

### PHM Program Overview

- A cornerstone of CalAIM launched in January 2023, each MCPs will have and maintain **a whole person-centered Population Health Management** (PHM) program.
- Several of the **key elements of PHM were already in place** in the Medi-Cal program prior to CalAIM through both Department of Health Care Services (DHCS) policies and MCPs' own programs.
- PHM is a journey rather than a destination. Over time, the program will evolve to support **more integration across delivery systems**, moving beyond the current requirements for MCPs.

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## Early in Our CalAIM Journey

**On January 1, 2022, DHCS launched the first components of CalAIM: Enhanced Care Management (ECM) and Community Supports.**

### Issues ECM & Community Supports are Designed to Address in California

Medi-Cal members typically have **several complex health conditions**

About 20% of Californians are **food insecure**

Enrollees with complex needs must often engage in **several delivery systems to access care**

People experiencing homelessness have **higher rates of diabetes, hypertension, HIV, and mortality**

Addressing social drivers of health is key to advancing health equity and helping people with high health care and social needs. **More than 65% of Medi-Cal members are from communities of color.**

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# Enhanced Care Management

**ECM provides person-centered, community-based care management to the highest-need members.**

- Assigns members a Lead Care Manager who is knowledgeable of community resources and services to coordinate both their clinical and non-clinical care
- Provides intensive coordination of health and health-related services across delivery systems, including primary and special care, dental, mental health, substance use disorder, and long-term services and supports
- Meets members wherever they are – on the street, in a shelter, in the doctor's office, or at home
- Is the highest level of care management that MCPs are required to provide as part of the broader CalAIM PHM program

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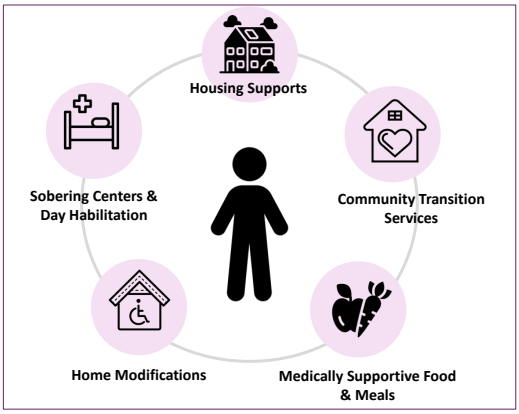
# Community Supports

**MCPs can offer Community Supports as cost-effective services that address social drivers of health and support members' clinical treatment goals.**

- Medically-appropriate, cost-effective services or settings that can substitute for more costly services or settings, such as hospitalization, skilled nursing facility admissions, or emergency department use
- Optional for the MCP to offer; as such, MCPs offer different combinations of Community Supports.
- MCPs must partner with local community-based organizations to provide culturally-appropriate services in members' communities
- Members do not need to be eligible for ECM to receive Community Supports

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# SNF Workforce & Quality Incentive Program (WQIP)

DHCS

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## SNF Workforce & Quality Incentive Program

- WQIP will provide directed payments to Skilled Nursing Facilities (SNFs) through the managed care delivery system to succeed the former fee-for-service Quality and Accountability Supplemental Payment (QASP)
- WQIP will target payments of $280 million in the first year with annual growth. Payments will be made by MCPs to facilities starting in CY 2024 for utilization/performance in CY 2023.
- DHCS aims to align managed care plan quality and performance reporting with the quality measures being monitored at the facility level through the WQIP.

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## Major Changes from QASP

- The WQIP is intended to more broadly distribute funding to incentivize workforce, quality improvement, and equity as a core part of facilities' reimbursements, compared to QASP which provided a smaller bonus only to the highest performing facilities.
- WQIP includes several new metrics including workforce, claims-based clinical metrics, and equity metrics in addition to Minimum Data Set (MDS) clinical metrics used in QASP.
- All facilities will be able to earn a WQIP payment proportional to their WQIP score between 0 and 100.
- WQIP will provide a greater opportunity for facilities to earn points for achievement or improvement on clinical metrics.

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## WQIP Metrics

| Percent of Total Score | Measurement Area | Number of Metrics |
|---|---|---|
| 35% | Workforce: Acuity-Adjusted Staffing Hours | 5 |
| 15% | Workforce: Staffing Turnover | 1 |
| 20% | Clinical Quality: Minimum Data Set | 3 |
| 20% | Clinical Quality: Claims-based | 3 |
| 7% | Equity: Medi-Cal Disproportionate Share | 1 |
| 3% | Equity: Racial & Ethnic Data Completeness | 1 |

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## Workforce Metrics

Using CMS Care Compare and Payroll Based Journal:

- Acuity-Adjusted Total Nursing Hours
- Acuity-Adjusted Weekend Total Nursing Hours
- Acuity-Adjusted Registered Nurse (RN) Hours
- Acuity-Adjusted Licensed Vocational Nurse (LVN) Hours
- Acuity-Adjusted Certified Nursing Assistant (CNA) Hours
- Total Nursing Staff Turnover

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## MDS Clinical Metrics

- Percent of High-Risk Residents with Pressure Ulcers, Long Stay (CMS Metric)
- Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay (CMS Metric)
- Percent of Residents Who Received an Antipsychotic Medication, Long Stay (CMS Metric)

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## Claims-based Clinical Metrics

Calculated using claims data for Medi-Cal beneficiaries and Medicare dual-eligible beneficiaries:

- Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days (CMS Metric)
- Healthcare-Associated Infections Requiring Hospitalization (CMS Metric)
- Potentially Preventable 30-Day Post-Discharge Readmission (CMS Metric)

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## Equity Metrics

- Racial & Ethnic Data Completeness in MDS, over 90 percent
- Disproportionate Share of Medi-Cal Days above the 50$^{th}$ percentile using Medi-Cal claims, compared to peer facilities,

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## Additional Information

- Additional information on CalAIM is available on DHCS.ca.gov/CalAIM
- Additional information on WQIP and other Nursing Facility Financing reforms is available on DHCS.ca.gov/AB186

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# CDPH

Chelsea Driscoll
Public Policy & Prevention Division Chief

March 27, 2023

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## Ryan's Law

- Ryan's Law, also known as the Compassionate Access to Medical Cannabis Act, requires general acute care hospitals (GACHs), skilled nursing facilities (SNFs), congregate living health facilities (CLHFs), special hospitals (SHs), and hospice facilities (HOFAs) to permit terminally ill patients to use medicinal cannabis.
- Facilities are not required to either provide or furnish the patient with a recommendation to use medicinal cannabis.
- All facility health care professionals and staff, including pharmacists, are prohibited from administering or retrieving a patient's medical cannabis.

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## Ryan's Law

- Patients or their primary caregivers must assume full responsibility for acquiring, retrieving, and administering the medicinal cannabis and removing it when the patient leaves the facility.
- The medicinal cannabis also must be securely stored in a locked container in the patient's room, other designated area, or with the patient's primary caregiver.

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## Initial Examinations

- Title 22 allows physicians and other licensed healthcare providers acting within their scope of practice to conduct the initial examination of a SNF resident that must be completed within 5 days prior to admission or within 72 hours following admission.
- Under federal law, a physician must conduct the initial comprehensive visit for a SNF resident within 30 days of admission
- Following the initial visit a nurse practitioner may conduct necessary visits going forward. These visits should occur at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

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## Virtual Visits

- Initial comprehensive physical exams required under current law must be performed in person.
  - At this time, California does not allow the exam by to be done remotely.

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## Medical Director

- SNFs shall not contract with a person as a medical director if the person is not, or will not be within five years of the date of initial hire, certified by the American Board of Post-Acute and Long-Term Care Medicine, or an equivalent organization, as a Certified Medical Director.
- A medical director already employed in a SNF as of January 1, 2022, shall have until January 1, 2027, to become a Certified Medical Director.

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## Medical Director

- All SNFs should have reported to CDPH no later than June 30, 2022, the name and certification status of the facility's medical director by submitting the following information on its medical director:
  - An HS 215A form
  - A résumé
  - Whether its medical director is certified as a Certified Medical Director by the American Board of Post-Acute and Long-Term Care Medicine
  - If the medical director is not yet certified, the expected date of certification

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## Medical Director

- SNFs must notify CDPH within 10 calendar days of any changes in their medical directors by submitting an HS 215A form or its successor form, a résumé, and proof of certification or progress towards certification for its new medical director.
- SNFs must also submit this information on their initial licensing applications.

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## Medical Director

- Medical director requirements for distinct-part SNFs are slightly different.
- Hospitals with DP/SNFs must designate a qualified physician as medical director, where qualified physician means either of the following:
  - The physician is certified, or pursuing certification, by the American Board of Post-Acute and Long-Term Care Medicine as a Certified Medical Director.
  - The physician is board certified in a medical specialty consistent with the type of care provided in the SNF, and the physician's role as the medical director of the SNF has been reviewed and approved by the hospital's leadership.

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## Infection Preventionist

- A SNF must have a full-time, dedicated Infection Preventionist (IP)
  - Either one full-time IP staff member OR two staff members sharing IP responsibilities if the total time dedicated to the IP role is at least equal to that of one full-time staff member
- IP requirements
  - Primary professional training as a licensed nurse, medical technologist, microbiologist, epidemiologist, public health professional, or other health care related field
  - Qualified by education, training, clinical or health care experience, or certification
  - Completed specialized training in infection prevention and control

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## End of State of Emergency

- California's State of Emergency proclaimed on March 4, 2020, is terminated effective February 28, 2023.*
  - Executive Orders related to the terminated State of Emergency are no longer in effect, e.g., certain temporary waivers.
- On Friday, March 3, 2023, CDPH announced changes to State Public Health Officer Orders and guidance:
  - Masking in healthcare and other high-risk settings
  - Vaccine requirements for healthcare personnel (HCP)

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## HCP Vaccination

- CDPH continues to strongly recommend that all HCP and high-risk individuals remain up to date on COVID-19, influenza, and other recommended vaccines.
- Beginning April 3, 2023, the state of California will no longer require vaccination and boosters for HCP.
- Per CMS QSO 23-02-ALL, CMS continues to require HCP to have received the COVID-19 primary vaccine series, unless exempted.
- Local health departments and healthcare facilities may implement COVID-19 vaccination requirements for HCP.

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## Masking Guidance

- Beginning April 3, 2023, California will no longer require masking in indoor healthcare settings.
- CDPH recommendations are now tied to the CDC's COVID-19 Community Levels based on hospitalization rates, hospital bed occupancy, and COVID-19 incidence:

| CDC Community Level | Individuals in the Community | Staff and Patients/Residents in Indoor High-Risk Settings |
|---|---|---|
| Low | Personal preference; consider if vulnerable | Consider |
| Medium | Everyone consider; recommended if vulnerable | Recommended |
| High | Everyone recommended; strongly if vulnerable | Strongly recommended |

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## Updated Guidance

- CDPH is reviewing all COVID-19 related guidance and will be rescinding or archiving outdated information

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Thank you!

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