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SPEAKERS

Alisa Chester
Bambi Cisneros
Cori Mallonee
Michael Jordan

Alisa Chester:

Hello and welcome to the CalAIM: Subacute Care Facility Carve-In Billing & Payment Webinar. Thank you for joining us today. My name is Alisa Chester and I'm with Aurrera Health Group supporting the California Department of Health Care Services. Next slide. A few things to note before we begin. This webinar is being recorded. The webinar recording and slides will be posted to the DHCS Subacute Care Facility Long-term Care Carve-In webpage shortly after today's presentation. Participants are currently in listen-only mode, but can be unmuted during the Q&A discussion periods. To participate in the Q&A discussion, please use the raise hand feature and our team will unmute you. You can also use the chat feature to submit any questions that you have. You can feel free to type in questions at any point in time. Our team will be monitoring the chat. This webinar is also going to include several Q&A opportunities. Next slide.

Alisa Chester:

We would just ask that you take a minute now to add your organization's name to your Zoom name so that it appears as your name-organization. You can do this by hovering over the participant's icon at the bottom of the window. Hover over your name, select rename, and enter your name and add your organization as you would like it to appear. Now, I'm going to turn it over to Bambi Cisneros, Assistant Deputy Director of Managed Care at DHCS.

Bambi Cisneros:

Hi, everyone. Good afternoon. Thank you, Alisa, and thank you everyone for your time in joining us this afternoon. So what we aim to accomplish today is to give an overview of the Subacute Care Facility Carve-In, review the payment policy that is outlined in our All Plan Letter, provide information on billing and an overview and promising practices, as well as review how Subacute Care Facilities can prepare for the transition. We will also have several opportunities for Q&A throughout the presentation before we close out. So, we can go to the next section please. We can start with a brief overview of the Subacute Care Facilities Carve-In to start. So CalAIM has multiple initiatives, and the Long-Term Care Carve-In is part of the benefit standardization initiative. The goal for benefit standardization is exactly what it sounds like, which is to make coverage of institutional Long-Term Care consistent across all counties statewide, which today it varies by plan, model type, and by county.

Bambi Cisneros:

And the Department is carving in Long-Term Care into managed care and implementing that into two phases. And so earlier this year on January 1, 2023, Medi-Cal managed care plans began to cover the Long-Term Care services for Skilled Nursing Facilities. And then Phase 2, which is effective January 1, 2024, will include the provision of Subacute Care and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). So we have the ICF/DDs, ICF/DD-H for habilitative and ICF/DD-Ns for nursing. And so, all of these facility in our Home types we'll be carving into managed care January 1st, 2024. And DHCS did issue All Plan Letters as guidance for our managed care plans for each of these transitions and we provided those links on this

page. The next slide please. So in today's environment, coverage of subacute care services differ in managed care depending on the county, as I had mentioned. In the 22 County Operated Health Systems counties or COHS counties, plans cover adult and pediatric subacute services. And then in five non-COHS counties, plans cover only adult subacute care services.

Bambi Cisneros:

And in the remaining 31 counties, plans cover for a limited time, which is from the time of admission into the facility and up to one month after the month of admission. And if the member needs subacute care services longer than that, the plan is required to disenroll the member and transfer them to Fee-for-Service to continue receiving the services. Okay, go to next slide please. So, when the Carve-In to managed care happens effective January 1st, 2024, the counties listed here on this slide will be newly transitioning from Fee-for-Service to managed care coverage. And we did also include in the appendix of the slide deck a list of all counties in California and associated managed care plans, in addition to whether adult or pediatric subacute care services are being carved in. So, I wanted to provide that as a reference. Okay, next slide please. So, the Carve-In change on January 1st, 2024 will impact approximately 2,000 Medi-Cal members that are currently in Fee-for-Service.

Bambi Cisneros:

And then all Medi-Cal only and dual eligible beneficiaries and Medi-Cal Fee-for-Service that's residing in a subacute care facility on January 1st, 2024, will be enrolled into a Medi-Cal Managed Care Plan effective January 1, 2024. And with that I will now transition to Michael Jordan with our Capitated Rates Development Division to provide an overview of the directed payment policy and payment requirements.

Michael Jordan:

Thank you, Bambi. And hello everyone, I'm Michael Jordan from Department of Health Care Services in the Capitated Rates Development Division. So next we'll cover the directed payment policy and payment requirements. Certain important details I will have to read directly from the slides, but let's dive in. So managed care plans in counties where coverage of adult or pediatric subacute services is newly transitioning from the Fee-for-Service delivery system to the managed care delivery system must reimburse network providers of adult or pediatric subacute care services for those services at exactly the Medi-Cal Fee-for-Service per-diem rates that are applicable. So essentially a floor and a ceiling at the Fee-for-Service rate, no more and no less. The 31 counties where adult and pediatric subacute LTC services will be new for managed care plans are listed on the bottom of the slide. Next slide please. All right, so this slide now addresses how the state directed payment policy applies in counties where adult or pediatric subacute services were already covered in managed care.

Michael Jordan:

So, in other words, an existing benefit prior to January 1st, 202. And you'll notice how this differs from newly transitioning counties in that the state directed payment imposes

a floor at the Fee-for-Service per-diem rate but not a ceiling above the Fee-for-Service rate. So again, managed care plans in these counties where adult or pediatric subacute was already a Medi-Cal Managed Care covered service must reimburse network providers of these adult or pediatric subacute care services for those services at no less than the Medi-Cal Fee-for-Service per-diem rate that is applicable to that particular type of provider. And similar to the last slide we do list, I don't know if we want to go back just briefly, but the 27 counties where these are currently covered under managed care are listed on the slide.

Michael Jordan:

All right, next slide please. So other payment requirements, this state directed payment requirements that we spoke about in the past two slides, they only apply to payments made directly for adult or pediatric subacute care services. These directed payment requirements do not apply to other types of payments, including but not limited to, provider incentive and pay-for-performance payments. And elaborating on this a bit further, if there is a member that is currently receiving these adult or pediatric subacute services, this state directed payment requirement, it does not apply to any other services provided to the member such as, but not limited to, if the member is receiving subacute services provided by an out-of-network provider or other non-subacute care services. So another point here is that these non-qualifying services are able to be negotiated between the managed care plan and provider, and also payable by managed care plans in accordance with these negotiations. And again, this does mean that managed care plans and providers can negotiate ancillary services outside of the per-diem rate. Next slide please.

Michael Jordan:

I think this is about halfway through the slides I'm covering. This one covers certain payment expectations for the managed care plans. So managed care plans are required to pay claims timely. There are two main authorities here. So the first is in accordance with the prompt payment standards within their contracts and then also DHCS guidance including APL 23-020. And this details requirements for timely payment of claims. Another expectation is that DHCS expects managed care plans to pay clean claims within 30 calendar days of receipt. Additionally, managed care plans are highly encouraged to remit claims and invoices in the same frequency in which they are received. Finally, on this slide we do want to note that the plans must ensure that providers of subacute care services receive reimbursement in accordance with these requirements for qualifying services and that's regardless of any subcontractor arrangements. Next slide please.

Michael Jordan:

All right. So, the subacute care All Plan Letter provides additional information about payment requirements, some of which are outlined below. So I'll read these off briefly to you all. Managed care plans must have a process for Subacute Care Facilities to submit electronic claims and receive claims electronically. Managed care plans must also ensure the Subacute Care Facility and its staff have appropriate training on benefits coordination including balanced billing prohibitions. And lastly on this slide, MCPs must

coordinate benefits with Other Health Coverage, and this includes recognizing other health coverage as the primary payer and Medi-Cal as the payer of last resort. Let's see. Under Continuity of Care protections, providers will continue to receive payment for subacute care services to effectively comply with the Continuity of Care requirements. MCPs will need to contract with Subacute Care Facilities in which their members reside and also may need to offer single case agreements in the interim.

Michael Jordan:

And next slide please. All right, and this is the final slide I will be covering today. The Subacute Care Facility Carve-In does not make changes to the coverage policies for pharmacy benefit coverage and it does not make any changes to Medi-Cal Rx. The Fee-for-Service Medi-Cal Subacute Care per-diem rate does not include legend or prescription drugs. And for managed care plans newly covering subacute care services starting the first of the year, and for managed care plans that do not include prescription drugs in their contracted Subacute Care Facility rates. The financial responsibility for prescription drugs is determined by the claim type of which they are billed. So going into a bit further detail here are two scenarios. So, the first one is, if drugs are dispensed by a pharmacy and billing on a pharmacy claim, they are carved out of the managed care benefit and covered by Medi-Cal Rx. However, so if drugs are provided by the Subacute Care Facility and billed on a medical or institutional claim, they are covered by the managed care plan.

So, this concludes my portion of the webinar. Thanks everyone. I will now transition to Cori Mallonee with our Subacute Contracting Unit.

Cori Mallonee:

Thank you. Managed care plans in all counties must ensure that members in need of adult or pediatric subacute care services are placed in a freestanding or a distinct part Skilled Nursing Facility that is under contract with Department of Health Care Services Subacute Contracting Unit or is actively in the process of applying for a contract with us. This means that even facilities currently contracted with managed care plans in counties where subacute care services are already covered under managed care must receive a contract from the Subacute Contracting Unit or apply for a contract with us in order to continue receiving Medi-Cal Subacute Reimbursement. This requirement ensures that freestanding and distinct parts Skilled Nursing Facilities receiving Medi-Cal subacute care reimbursement meet certain standards and that members residing in these facilities do not experience disruptions to access to care. Next slide, please. To receive Medi-Cal Subacute Reimbursement after December 31st, 2023, freestanding and distinct parts Skilled Nursing Facilities must be contracted with us or must submit an application to us by December 15th, 2023.

Cori Mallonee:

If your facility is not contracted with us, please contact subacute2@dhcs.ca.gov as soon as possible to request an application. You can view a list of Skilled Nursing Facilities contracted for subacute care on our website or linked here on the slide. To ensure access to care during upcoming transition, we will process applications for all new

contracts as quickly as possible, and we will post a list of facilities that have applied for a contract on our website to allow plans to continue to reimburse those facilities during the application process. For any questions regarding subacute care or on contracting with us, please email subacute2@dhcs.ca.gov. I'll now hand it back to Bambi. Thank you.

Bambi Cisneros:

Great, thank you Cori. So, we want to highlight an important resource for subacute care providers. DHCS required the managed care plans to identify an individual or group of individuals to serve as the liaison to the Long-Term Services and Supports community, which include the Subacute Care Facilities. And so we envisioned the LTSS Liaison to be the single point of contact for providers and would be serving in both a provider representative role, particularly to help address claims and payment inquiries as well as the support care transitions. And the idea is that the individual or group of individuals is well versed in the Long-Term Care policies that we're discussing here and can work with providers as they learn to work with their managed care plans through this transition. We did ask the managed care plans to share their LTSS Liaisons contact information with their network providers and then also update those providers if there were any changes to the LTSS Liaison assignments. And with that I will now hand it back to Alisa with Aurrera Health.

Alisa Chester:

Thank you. I'm just going to spend a few minutes talking about included and excluded services in the per-diem rate. And Bob, we saw your question, so hopefully this helps answer some of those questions about which services can be negotiated outside of the per-diem rate. So on this screen you can see the per-diem rates for adult and pediatric subacute care include all services, equipment, and supplies necessary for the administration of treatment procedures listed in the patient care criteria for subacute care services. A few examples of those services are listed here on the slide. Just a quick note that occupational, physical, and speech therapy services are included in the adult subacute care per-diem rate. And on the pediatric side, occupational, physical, and speech therapy services are included in the pediatric per-diem rate if they are a part of a supportive maintenance program. In other words, part of routine daily care. Go to the next slide.

Alisa Chester:

In addition to the services listed on the previous slide, the per-diem rate for pediatric subacute care services includes registered dietician services, developmental services, and service coordinator activities. Next slide. Services outside the per-diem rate are not subject to the directed payment policy and would follow the MCP and provider's normal negotiation process. These exclusive items are separately reimbursable and subject to the utilization review controls and limitations of the Medi-Cal program. Exclusive items include supplies, drugs, equipment or services such as durable medical equipment, lab services, and X-rays, dental services. It is important to note that not all Subacute Care Facilities provide these services that MCPs will need to ensure coverage of those

medically necessary services regardless. This means that services will be covered but may be provided outside of the facility. Next slide.

Alisa Chester:

MCPs must also cover the following services with additional TAR approval, but these are not included in the pediatric subacute per-diem rate. This includes supplemental rehabilitation therapy services and Ventilator Weaning Services. More information on these can be found in the provider manual. The appendix of this slide deck as well as attachment A in the Subacute Care Carve-In APL has a detailed list of inclusive and exclusive services. Go to the next slide. Now we'll take a few minutes to answer some of the questions that we've received. All right, I'm going to start with Doug. "As I quickly read the slide, Riverside and San Bernardino counties are shown as not currently paying pediatric sub-acute facilities via HMOs, yet, I believe they are." I'm not sure if anyone from MCOD has thoughts on this. If not, Doug, if you would like to email us, we can look into this further. From Bob Nydam "Will there be an overall list of liaisons for each MCP in California with contact information?" So if you don't have contact information for your-

Dana Durham:

Yeah. And Alisa, let me just chime in on that one.

Alisa Chester:

Yeah, go ahead.

Dana Durham:

Yeah, we're not publishing a list and the reason for that is because we want to make sure those liaisons are available to the providers and to others who really need that contact and that there's not a list out there that someone's searching for and just calls the liaison who is totally dedicated to making sure that relationship between the providers and the plans is appropriate. So just wanted to give you a little more context into why we're not providing that. But, do note that Bambi put in the chat where you could get the list.

Alisa Chester:

Thank you. From Bob, "My understanding is that transportation is included in the subacute rates for MCPs. Based on your last side, it appears that is incorrect. Please advise." Our understanding is that transportation services are excluded from the subacute per-diem rate. Dana, did you want to weigh in?

Dana Durham:

Yeah, I mean the managed care plans are responsible for transportation, but it's not included necessarily in the subacute rates. But one of the things I do want to note is oftentimes the managed care plans have contracts and you do need to use that network provider with the managed care plan for that transportation.

Alisa Chester:

Thanks. From Jankel, "Currently there is a seven-day bed hold for hospitalization and other leaves. How will this be handled since there is not a matching revenue code?" I don't know if someone can speak to bed holds?

Adrienne McGreevy:

I actually can kind of speak to this because this is regarding the code conversion and there are accompanying revenue codes and I believe we do have information on the code conversion links that we can provide, hopefully in the chat.

Alisa Chester:

Yes.

Adrienne McGreevy:

And you will find corresponding codes for subacute care, ventilation, non-ventilation, pediatric, etc.

Alisa Chester:

Great. We will add those links into the chat here as well. David from HealthNet said, "For HealthNet you should refer to your contract for coding." So, there will be some coding questions that will be able to be answered directly from the managed care plan that you're contracting with. All right, I'm seeing some questions slow down so we can go to our next section and I'm going to turn it back to you Bambi.

Bambi Cisneros:

Okay, thank you Alisa. So, we will move on to the overview of billing and some promising practices. And so, to the next slide please. So here we have lifted up that it is imperative for managed care plans to pay Subacute Care Facilities in a timely fashion. We are aware that some Subacute Care Facilities often do not have the financial reserves as other types of providers and so are really relying on that kind of prompt payment as the shift happens from Fee-for-Service to managed care plans. Managed care plans and facilities should be working together to ensure that the Subacute Care Facilities are set up to receive payment either via EFT, if the EFT is requested by the facility. There may still be some kind of invoicing processes. I think most subacute facilities are on EFT, so that's something to set up ahead of time. Some of the promising practices that we would share include for plans to provide a shorter payment timeframe for clean claims. Managed care plans are subject to contractual requirements to pay clean claims within 30 days. It's in their contract.

But nothing would preclude them from paying this within a shorter timeframe as long as the claim is clean. And so from the provider's perspective, I think that is something that you should work with your managed care plan on so you could understand what that means when it's a clean claim and so that the claim could be then paid quickly. Also, one of the promising practices is to really kind of talk about these payment timeframes and options with the managed care plan that you're working with, if the Subacute Care

Facility does anticipate any cashflow challenges. That is one of the reasons why we had the plans identify an LTSS Liaison is to really work with the providers on this transition to make sure it's smooth and as seamless as possible, not just for members but for providers as well, as providers new to working with managed care plans or trying to learn the plans and their systems and things of that nature. And so we would have you contact the Managed Care Plans LTSS Liaisons for any support and help in resolving any of these claim challenges.

Bambi Cisneros:

Okay, the next slide please. So we kind of touched on this a little bit in the previous slide, which is that Subacute Care Facilities would need to submit clean claims in a timely manner for managed care plans to then process those claims as they come in. Some Subacute Care Facilities may require support from the managed care plan. Again, those that are really new to working in the managed care environment as they build their knowledge of how plans work in this space. And each plan can have different kind of claims billing processes, systems and protocols. So it's important to really work with your managed care plan to understand what those are as well as their clean claims requirements. And some of the promising practices that we would lift up of course is that managed care plans and Subacute Care Facilities would work together to really make sure that they're aligned in their understanding of claims requirements on both sides.

Bambi Cisneros:

We are aware that managed care plans are offering trainings, office hours and other kind of open door approaches to working with their providers and training and providing education to their subacute providers newly working with the plan. And then Subacute Care Facilities should also get familiar with the managed care plans resources, including any training materials that they're putting out as well as just knowing who the LTSS Liaison is on the plan side. The next slide please. And then here are some tips for some clean claim submissions. There are several general steps that facilities can take to help ensure that they're submitting clean claims. And so first they should validate the billing codes with managed care plans, just to ensure that the appropriate codes are being utilized. Something that I saw in the chat earlier from one of the managed care plans facilities should also confirm that certain elements line up.

Bambi Cisneros:

So that means including verifying that the dates of service on the claim reflect only the dates for the services rendered, for example, and then the dates of service on the claim should match the approved dates within the authorization. Because if the dates do not match, a reauthorization may be required so just really important to get those details down. The patient status code should also agree or be aligned with the revenue code. So for example, if the status code indicates leave days, the accommodation code must also indicate leave days. And then for bed holds, check regularly for residents on leave at an acute hospital or transferred to another Long-Term Care facility. And then if a member was transferred to another facility, would also recommend verifying the facility to which the resident was transferred to is also billed correctly. Okay. So we can move

on to the next segment. In terms of some tips on what providers can expect ahead of this transition.

Bambi Cisneros:

Okay. So what can subacute care providers expect? So managed care plans are held to network readiness requirements that are of a certain... Requirements that DHCS has imposed and managed care plans, we do expect plans to have a robust provider network including Subacute Care Facilities. And so we do expect plans to attempt to contract with all adult Subacute Care Facilities in the plans county, and all pediatric Subacute Care Facilities statewide. And would also have plans attempt to contract with facilities where their Medi-Cal members currently reside. So that's kind of a focus area that plans should be looking at. Managed care plans have a team dedicated to working with Long-Term Care providers to address contracting authorizations claims and issue resolutions. And plans should also be partnering with their subacute care providers to ensure a smooth transition and to work out any issues that may arise particularly ahead of the transition.

Bambi Cisneros:

And as I mentioned earlier, plans are offering trainings and opportunities to educate their providers on authorizations and claims processes, particularly the clean claims requirements, which is really important for timely payments. Then of course the LTSS Liaison, which is really there to support and help resolve claims challenges. And then we are aware that many managed care plans do have online provider portals that contain resources and information and communications related to claims and payments. So we do encourage that you work with the plans on that as well. And then moving on into the next slide, we go into a little bit about facilities building relationships with managed care plans. And so of course you would want to work with your managed care plan early to obtain some key information on the plan's authorization processes, their billing and payment processes, and also attend any education and training opportunities that they're offering. And then the facilities and managed care plans should also work together in identifying any potential Continuity of Care issues for Medi-Cal benefits that's not included in the per-diem rate.

Bambi Cisneros:

Some of which we talked today just to make sure that members have day one coverage. Managed care plans are responsible for the full array of Medi-Cal covered services, whether or not Subacute Care Facilities provide that and so it would be good to learn the plans benefit package there. And then managed care plans can support the Subacute Care Facilities also by providing outreach education and support. So if you have not heard from your managed care plan yet, you should be soon, as we did ask them to do some outreach and to start really building those relationships. And then of course, managed care plans and the Long-Term Care providers do need to work collaboratively and then reach out to the LTSS Liaison to resolve any issues in a timely manner. And so, with that I will turn it over back to you Alisa.

Alisa Chester:

Great, thank you. So for folks, please feel free to ask your questions in the chat or raise your hand. We have a couple of questions to start wit. From Doug, "How will MCPs be penalized for late payments and who is in charge of that at the state?" We put in a link there to APL 23-020 on timely payment requirements for plans. It also includes information about dispute resolution requirements. But Michael or Adrienne, let me know if you want to add onto what we have there.

Bambi Cisneros:

Yeah, maybe I could just layer on a little bit, Alisa, on that. We work with our managed care plans in different ways and of course I think the APL that's provided there lists out the timely payments requirements that goes into a little bit more detail than what is contractually required. And we have full and broad sanctions authority that's established in state statute. But with that being said, we do work very closely with our managed care plans. We have normal communication channels with them where we are open to make sure that they understand the policies and can clarify and ask questions. And also one of the things I would mention is that we are going to be monitoring this transition very closely, in particular, when it comes to timely payments. And so with that kind of very regular reporting from the managed care plans, we can very quickly see if there's any concerns out in the field so that we can work with the plans to address. So hopefully that helps.

Alisa Chester:

Great, thanks Bambi. A couple of questions on supplemental rehab therapy. From Bob, "Have there been any trainings for MCPs on how supplemental rehab therapy works? This can be confusing. Are the authorization for claims and billing for supplemental rehab therapy for MCPs the same as it is for Fee-for-Service since there has been confusion in the past?" I'm not sure if anyone wants to start here?

Bambi Cisneros:

If we have any plans on the call as well it might be good if they could share also what they've kind of been doing in regards to training in this area as well.

Alisa Chester:

Yeah, a requirement for plans is to be familiar with all Long-Term Care Carve-In benefits including supplemental rehab therapy and how it works. The authorization for claims and billing will not be the same but will probably look the same for MCPs compared to fee for service, but we would defer to plans on what it looks like there. And from Wendy, "To add to the question above will each MCP define what maintenance and supportive rehab services are?" And I think the answer to that is no because it's based on existing materials. I think we have an FAQ on that that I can pull up. Do any plans want to weigh in on billing and payment for supplemental rehab therapy? If you raise your hand we can unmute you. Yeah, Bob, you can go ahead if you raise your hand, we'll unmute you. There we go.

Bob Nydam:

Yeah. Hey, this is Bob Nydam, I'm at Totally Kids Sun Valley. The challenge with supplemental rehab therapy in the freestanding and the DP subacutes is that the authorizations are done differently than most of the SNFs and that sort of thing, so the MCP could easily get confused. We've had massive confusion in the past with Medi-Cal itself on this very issue because we are paid on a per-diem rate, not a per-therapy rate. So we have to meet a certain criteria where a patient is assessed, evaluated, and if they meet that criteria, then we get a specific rate for those seven days weekly, based on whatever therapy they're going to have that week that's been approved. So it's not, you're paying for Thursday's physical therapy and Wednesday's occupational therapy, it's a seven-day per-diem rate for that week. This has been incredibly confusing for Medi-Cal itself and the field offices and this has been very confusing for the MCPs that we've experienced.

Bob Nydam:

We've tried to educate the MCPs, and they've been very receptive to it, but still, it's really something to think about because it causes confusion because there's this little slice of pediatric subacutes that does it different than everybody else, because we're on a modeled rate and everything's per-diem. So just clarifying.

Bambi Cisneros:

Yeah, thank you for bringing that to our attention, Bob. So, I know in our All Plan Letter we talk about how these services are kind of in addition to the per-diem rate and then there's a separate kind of authorization request required for these services. But it sounds like in working with some managed care plans and kind of clarifying further on what that might look like, that might be something we may want to issue as an FAQ, just provide guidance for plans who are just not as familiar. So if you can share with us what you think might be helpful clarification, we're happy to share that out with the managed care plans as well. We don't want there to be any confusion.

Bob Nydam:

Oh yeah, let me respond real quick. I appreciate that. Yeah, and basically it’s in all the documentation on the DHCS website and that sort of thing. But I will definitely send that over to the LTC transition email, but it's clearly spelled out but it needs education to understand it even further, so I appreciate that.

Bambi Cisneros:

Okay, got it. Thank you. Yeah, that would be great. Thank you so much.

Alisa Chester:

Great. We have another question. "For LTC claims should we be billing weekly as we did to Medi-Cal Fee-for-Service? What is preferable as these can be considered high dollar amount claims and have historically taken longer to pay?" Bambi, do you want to take this one?

Bambi Cisneros:

Yeah, I can respond. So for this, so for providers, I think really they could bill in the cadence. I know you're probably used to submitting and getting a weekly check right to medical Fee-for-Service. And you can do that with the plans as well, I mean, I think the important part here is that the claim really is that understanding to make sure that the claim is clean so that the plan could pay it as promptly as possible. Now I had mentioned earlier that plans do have up to 30 days to pay the clean claim, which understood is a little bit longer than probably what occurs in Fee-for-Service and so what we have encouraged plans to do is to pay in the cadence in which the clean claim is received. So I think their understanding and what we have shared is that if the claim is clean, they wouldn't be holding onto the claims for 30 days, for example. And can pay it right away. Which is why it's really important to really work with the plans to understand what the clean claims look like so that that way they could really pay that as promptly as possible.

Alisa Chester:

Great. I have another question here that I'm going to kick to Dana from Don. "Does CCS play a role in any authorization and reimbursement for the pediatric SA population with a CCS condition and a service provider under that condition?"

Dana Durham:

So if it's a CCS condition and the plan is not Whole Child Model, then CCS is responsible for the payment. But managed care plans do work to coordinate and make sure that payment is received as well as coordination is done. But if it's a CCS condition specifically, if it's a child, then unless it's a Whole Child Model, it would be under CCS.

Alisa Chester:

Great. Thanks Dana. All right, it looks like we've gotten through the questions, but I'm going to pause here and give folks another moment if they have a question to raise their hand or enter it into the chat. We do have one question that was submitted beforehand related to transportation? If you can clarify charges, billing for medications, transportation... Oh excuse me, are we going to use IEHP Transportation Form and submit it to IEHP Transportation Department? This is related to one of the other questions that we had. Dana, go ahead.

Dana Durham:

Yeah, I mean each managed care plan has their own processes for transportation and it's for transportation for the member. And just want to make sure that, I don't know which particular form you're talking about, but if it is their transportation form, I would suspect that that's the correct form. But I'd make sure I'd talk with the managed care plan to ensure that you're filling out the correct form.

Alisa Chester:

Great. Thanks Dana. All right. I'm not seeing any hands or any other questions coming through the chat, so I think we can go to the next slide. All right. So our next webinar is called How Medi-Cal Managed Care Plans Can Support ICF/DD and Subacute Care

Facility Residents. It will be on December 15th and a registration link is available on the DHCS website. On the next slide, we have some links to additional resources. Updates to the Subacute Care Facility Carve-In including policy guidance and information on webinars and registration will be posted to the main webpage on the Subacute Care Facility Carve-In. We also have newly posted FAQs on the Subacute Care Facility Carve-In transition webpage. And I'll just take a moment to thank everyone for joining us today and thank our speakers. We look forward to your continued engagement on the Subacute Care Facility Carve-In. If you have any additional questions that were not addressed during this webinar, you can email LTCtransition@dhcs.ca.gov. We put that email in the chat there as well. Thanks everyone. Oh, I see one question, but yes, we will post the deck to the website. Thank you.

Bambi Cisneros:

Thanks everyone.