CALAIM SKILLED NURSING FACILITY AND SUBACUTE CARE FACILITY LONG-TERM CARE CARVE-IN: RESOURCES FOR MANAGED CARE PLANS

February 2024

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Contents

I. About This Document

Effective January 1, 2023, Medi-Cal Managed Care Plans (MCPs) in all California counties became responsible for Skilled Nursing Facility (SNF) services and effective January 1, 2024, MCPs in all California counties will become responsible for Subacute Care Services. The California Department of Health Care Services (DHCS) developed the California Advancing and Innovating Medi-Cal (CalAIM) Contracting Requirements and Model Language for the SNF and Subacute Care Facility Long-Term Care (LTC) Carve-In document as a tool for MCPs, SNFs, and Subacute Care Facilities to use for the 2023 transition (see Background section below). DHCS included key issues that stakeholders have raised as challenges in Medi-Cal Managed Care Plan (MCP) and facility contracting. This document is specific to SNFs and Subacute Care Facilities and includes:

Background

- Information about CalAIM, long-term care, and an implementation timeline.

SNF and Subacute Care Facility LTC Carve-In Contracting Requirements

- References to existing policies and procedures for MCPs, SNFs, and Subacute Care Facilities providing and covering services for Medi-Cal members, including the All Plan Letters (APLs 23-004 and 23-027), MCP outreach and engagement with SNFs and Subacute Care Facilities, and network readiness requirements.

SNF and Subacute Care Facility LTC Carve-In Promising Practices

- Lessons learned based on counties where LTC is already carved-in to managed care for MCPs and SNFs or Subacute Care Facilities related to outreach and communications, payment and authorization terms, and care management. The lessons learned have been critical in helping DHCS identify requirements for the LTC Carve-Ins, and the Department encourages MCPs and facilities to use this document when conducting outreach for contracting.

While this document highlights DHCS requirements for the SNF and Subacute Care LTC Carve-Ins, the promising practices within this document are not requirements. Rather, they are intended to be a resource for stakeholders as the Medi-Cal health care delivery system in California transitions towards the LTC Carve-Ins.

II. Background

About California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multi-year DHCS initiative to improve the quality of life and health outcomes of Medi-Cal members by implementing broad delivery system, program, and payment reform across the Medi-Cal program. CalAIM seeks to address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations with significant clinical needs, and the growing aging population. The reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and focuses on improving outcomes for all Californians.

CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality and health equity outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Specifically, CalAIM includes an effort to carve-in LTC to Medi-Cal managed care statewide, as part of an overall shift towards Managed Long-Term Services and Supports (MLTSS). Goals for this broad MLTSS effort include:

- Improved Care Integration;
- Person-Centered Care;
- Leverage California's Robust Array of Home and Community-Based Services (HCBS);
- Build on Lessons and Success of Cal MediConnect (CMC) and the Coordinated Care Initiative (CCI);
- Support the Governor's Master Plan for Aging; and

- Build a Multi-Year Roadmap to integrate CalAIM MLTSS, Dual Eligible Special Needs Plans (D-SNPs), and Community Supports policy, the Master Plan for Aging, and all HCBS, to expand and link HCBS to Medi-Cal managed care and D-SNPs.

About the Long-Term Care (LTC) Carve-In

Under CalAIM, Medi-Cal MCPs will cover and coordinate Medi-Cal institutional LTC in all counties in a phased approach by facility type.[1] Effective January 1, 2023, all MCPs are responsible for the full LTC benefit at the following facility types and homes:

- SNFs, both freestanding and hospital-based SNFs.

SNFs are "health facility[ies] that provide skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis."[2]

Effective January 1, 2024, MCPs are responsible for the LTC benefit in the following settings:

- Intermediate Care Facility for Developmentally Disabled (ICF-DD);
- ICF-DD/Habilitative;
- ICF-DD/Nursing;
- Subacute Care Facility[3], including a distinct part of a hospital or freestanding facility and
- Pediatric Subacute Facility.
- Note: ICF/DD-Continuous Nursing Care homes are not subject to the LTC Carve-In policy.

Subacute patients require special medical equipment, supplies, and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care. Adult subacute care is a level of care that is defined as a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a

[1] Welfare & Institutions Code (WIC), Section 14184.201(b).
[2] California Health and Safety Code (HSC) Section 1250(c).
[3] In this document, Subacute Care Facility refers to facilities contracted by DHCS SCU.

skilled nursing facility.[4] Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.[5]

III. SNF Carve-In

This section focuses on the SNF services carve-in as part of the CalAIM institutional LTC services carve-in.

SNF Services in Carved-In Counties

Prior to January 1, 2023, Medi-Cal's LTC benefit for SNFs was already carved-in to Medi-Cal managed care in County Operated Health System (COHS) plan model and CCI counties. MCPs operating in these 27 counties were already contractually responsible for all medically necessary SNF services regardless of the length of stay in a facility under the institutional LTC benefit. In these counties, MCP members requiring long-term stays at SNFs continue to stay enrolled in their plan and do not disenroll to Medi-Cal Fee-For-Service (FFS) in order to receive SNF services. MCPs coordinated care and transitions of care with SNFs and other support services for members. MCPs are also responsible for contracting with SNFs as licensed by the California Department of Public Health (CDPH), enrolled in Medi-Cal and other credentialing standards, as applicable. MCPs must pay SNFs rates that are not less than Medi-Cal FFS rates (Assembly Bill 133 – Chapter 143, Statutes of 2021).

SNF Services in All Other Counties

In all other California counties (i.e., non-COHS and non-CCI), coverage of SNF services by MCPs was limited prior to January 1, 2023. MCPs were contractually responsible for medically necessary SNF services provided from the time of admission into a SNF facility and up to one month after the month of admission for SNF.[6] After this time, members

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[4] CCR Title 22 Section 51124.5 (a) and The Medi-Cal Provider Manual, Part 2 Long Term Care, Subacute Care Programs: Adult is available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=subacutadu.pdf.

[5] CCR Title 22 Section 51124.6 (a) and The Medi-Cal Provider Manual, Part 2 Long Term Care, Subacute Care Programs: Pediatric is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=subacutped.pdf.

[6] See Non-COHS, Non-CCI MCP boilerplate contracts at Ex. A, Att. 11, Prov. 18(A), located at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

continued to receive their SNF services in FFS. In these counties, MCPs were required to submit a disenrollment request to DHCS for members who require LTC in a facility for longer than the month of admission plus one month. Until DHCS approved the disenrollment, MCPs provided all medically necessary covered services to the members. Upon the effective date of disenrollment, MCPs were required to coordinate the member's transfer to the FFS program.

See Appendix Table A for the complete list of counties and whether the SNF carve-in went into effect on January 1, 2023, as well as 2023 and 2024 MCPs.

2023 SNF Carve-In Policy in All Counties

Members who entered a SNF after January 1, 2023, will remain enrolled in Medi-Cal managed care ongoing and will no longer be disenrolled from the MCP after the second month of admission. In addition, all Medi-Cal-only and dual eligible members in FFS residing in a SNF on January 1, 2023, were enrolled in an MCP effective January 1, 2023. Members were enrolled in the MCP of their choice.[7] However, if members did not choose an MCP, DHCS used an upfront provider linkage process that assigns a member to a MCP that works with their current LTC facility. If their LTC facility does not work with an MCP in the county, the default auto assignment process was used.

The goal of the SNF LTC Carve-In is to better integrate care and make the LTC delivery model consistent and seamless across all counties in California by reducing complexity and increasing flexibility through benefit standardization. MCPs can offer complete care coordination, care management, and provide a broader array of services for Medi-Cal members than the traditional Medi-Cal FFS system.

SNF Carve-In Member Demographics

Overall, based on 2024 data, the SNF population transitioning, like SNF residents overall, ware majority female and age 65 and older.

[7] Dual eligible members that reside in a county subject to the Medi-Cal Matching Plan Policy will be defaulted into a Medi-Cal managed care plan that matches their Medicare Advantage plan. The 12 counties that are subject to the Medi-Cal Matching Plan Policy include: Alameda, Contra Costa, Fresno, Kern, Sacramento, San Francisco, Stanislaus, Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara.

Table 1: Skilled Nursing Facility Carve-In Member Demographics

Member Characteristic	All Counties
Age	
0-17	--
18-64	4,390
65+	18,530
Sex	
Male	10,050
Female	12,880
Dual Eligible	
Dual Eligible Individual	18,580
Non-Dual Eligible Individual	4,350
Total	
Total	**22,920**

- **Source**: Data Extraction Date: January 18, 2024, from the DHCS Management Information System/Decision Support System (MIS/DSS) data warehouse.
- **Notes**: Numbers are rounded to the nearest 10 and may not sum to the total. The data has been suppressed in instances where values were at least one but less than 12, or whereby related data with values less than 12 not presented here could be deduced from the information in this table.

Table 2: SNF Residents by County Subject to Carve-In

County	Member Count	County	Member Count
Alameda	2,530	Orange	440
Alpine	--	Placer	300
Amador	60	Plumas	30
Butte	460	Riverside	560
Calaveras	50	Sacramento	1,540
Colusa	40	San Benito	40
Contra Costa	1,400	San Bernardino	590
Del Norte	--	San Diego	730

County	Member Count	County	Member Count
El Dorado	180	San Francisco	1,200
Fresno	1,430	San Joaquin	860
Glenn	40	San Luis Obispo	40
Humboldt	30	San Mateo	70
Imperial	180	Santa Barbara	40
Inyo	60	Santa Clara	350
Kern	860	Santa Cruz	150
Kings	140	Shasta	70
Lake	20	Sierra	20
Lassen	--	Siskiyou	--
Los Angeles	2,730	Solano	60
Madera	200	Sonoma	70
Marin	50	Stanislaus	690
Mariposa	30	Sutter	150
Mendocino	20	Tehama	70
Merced	50	Trinity	--
Modoc	--	Tulare	680
Mono	--	Tuolumne	100
Monterey	40	Ventura	--
Napa	90	Yolo	80
Nevada	150	Yuba	30
		Unknown	--
Total		**22,920**	

» **Source**: Data Extraction Date: January 18, 2024, from the DHCS MIS/DSS data warehouse.

- **Notes**: Numbers are rounded to the nearest 10 and may not sum to the total. The data has been suppressed in instances where values were at least one but less than 12, or whereby related data with values less than 12 not presented here could be deduced from the information in this table.
- The table includes members transitioning in counties where SNF services were not carved-in on January 1, 2023. There are several scenarios where members in these counties would transition from fee-for-service to managed care, including if the member was born in a county and transferred to a facility in a County Organized Health System (COHS) county, and the county plan is still responsible; or if claims history to validate the facility type is unavailable, or had a medical exemption that expired, or had an exclusion indicator that expired, or if the member is not active under an Long Term Care (LTC) aid code.

IV. SNF LTC Carve-In Policy Requirements

All Plan Letter 23-004: SNF LTC Benefit Standardization and Transition of Members to Managed Care

DHCS has released All Plan Letter (APL) 23-004, which supersedes APL 22-018, that outlines the requirements for implementing the SNF LTC benefit standardization and the transition of members to Medi-Cal managed care. DHCS has outlined the key requirements across the following domains:

I. Benefit Requirements
II. Network Readiness Requirements
III. Leave of Absence or Bed Hold Requirements
IV. Continuity of Care Requirements
V. Treatment Authorizations
VI. The Preadmission Screening and Resident Review
VII. Facility Payment
VIII. Population Health Management Requirements
IX. Long-Term Services and Supports Liaison
X. MCP Quality Monitoring
XI. Monitoring and Reporting
XII. Policies and Procedures

V. Subacute Care Carve-In

Subacute Care Services in Carved-In Counties

In certain counties, Medi-Cal's LTC benefit for Subacute Care Facilities was already carved-in to Medi-Cal managed care. In 22 COHS counties, MCPs provide coverage for both adult and pediatric subacute care services under the institutional LTC benefit.[8] In an additional five counties, MCPs cover adult subacute care services, but do not cover pediatric subacute care services.[9] This means that MCP members requiring long-term stays at Subacute Care Facilities continued to stay enrolled in their plan and did not disenroll to Medi-Cal Fee-For-Service in order to receive subacute care services.[10]

Subacute Care Services in All Other Counties

In the remaining 31 counties, prior to January 2024, MCPs covered Medically Necessary adult and pediatric subacute care services for members from the time of admission into a Subacute Care Facility and up to one month after the month of admission, after which members were disenrolled from Medi-Cal managed care and transferred to Medi-Cal FFS to continue receiving subacute care services.

In the five counties that covered adult subacute care services but did not cover pediatric subacute care services, members were also disenrolled from managed care after the month of admission and enrolled into Medi-Cal FFS to continue receiving pediatric subacute care services. MCPs were required to submit a disenrollment request to DHCS for the members who require subacute care services in a facility for longer than the month of admission plus one month.

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[8] The 22 counties where MCPs cover both adult and pediatric subacute services are: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

[9] The five counties where MCPs cover only adult subacute services are: Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara.

[10] The 31 counties where MCPs cover pediatric subacute services temporarily are: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, and Yuba.

Until DHCS approves the disenrollment, MCPs were required to provide all medically necessary covered services to the member and upon effective date of disenrollment, and coordinate the member's transfer to the FFS program.

See Appendix Table B for the complete list of counties and whether the adult/pediatric Subacute Care carve-in went into effect on January 1, 2024, as well as 2023 and 2024 MCPs.

2024 Policy in All Counties

Medi-Cal members who enter a Subacute Care Facility after January 1, 2024, will remain in Medi-Cal managed care ongoing and will no longer be disenrolled from the MCP after the second month of admission. In addition, all Medi-Cal only and dual eligible members in FFS residing in a Subacute Care Facility on January 1, 2024, were enrolled in an MCP effective January 1, 2024.

Subacute Care Facility Carve-In Member Demographics

Overall, based on 2024 data, the subacute population transitioning was more likely to be adult ages 18-64 and be male.

Table 3: Subacute Care Facility Carve-In Member Demographics

Member Characteristic	Pediatric Subacute	Adult Subacute
Age		
0-17	160	0
18-64	40	470
65+	0	210
Sex		
Male	110	430
Female	80	250
Dual Eligible		
Dual Eligible Individual	--	250
Non-Dual Eligible Individual	200	430
Total		
Total	200	680

» **Source**: Data Extraction Date: January 7, 2024, from the DHCS MIS/DSS data warehouse.

» **Notes**: Numbers are rounded to the nearest 10 and may not sum to the total. The data has been suppressed in instances where values were at least one but less than 12, or whereby related data with values less than 12 not presented here could be deduced from the information in this table.

Table 4: Subacute Care Facility Residents by County Subject to Carve-In

County	Pediatric Subacute	Adult Subacute
Alameda	--	100
Alpine	0	0
Amador	0	0
Butte	0	--
Calaveras	0	0
Colusa	0	0
Contra Costa	--	30
El Dorado	0	--
Fresno	--	60
Glenn	0	--
Imperial	0	--
Inyo	0	0
Kern	--	40
Kings	0	--
Los Angeles	70	170
Madera	0	--
Mariposa	0	0
Merced	--	--
Mono	0	0
Monterey	0	--
Orange	--	--
Nevada	0	0

County	Pediatric Subacute	Adult Subacute
Placer	--	--
Plumas	0	0
Riverside	--	20
Sacramento	--	30
San Benito	--	--
San Bernardino	50	60
San Diego	--	30
San Francisco	--	--
San Joaquin	--	30
San Mateo	0	--
Santa Barbara	--	0
Santa Clara	30	--
Solano	0	--
Sonoma	0	--
Sierra	0	0
Stanislaus	--	--
Sutter	0	--
Tehama	0	0
Tulare	--	40
Tuolumne	--	0
Ventura	0	--
Yuba	0	--
Total	**200**	**680**

- **Source**: Data Extraction Date: January 7, 2024, from the DHCS MIS/DSS data warehouse.
- **Notes**: Numbers are rounded to the nearest 10 and may not sum to the total. The data has been suppressed in instances where values were at least one but

less than 12, or whereby related data with values less than 12 not presented here could be deduced from the information in this table.

- The table includes members transitioning in counties where subacute care services were not carved-in on January 1, 2024. There are several scenarios where members in these counties would transition from fee-for-service to managed care, including if the member was born in a county and transferred to a facility in a County Organized Health System (COHS) county, and the county plan is still responsible; or if claims history to validate the facility type is unavailable, or had a medical exemption that expired, or had an exclusion indicator that expired, or if the member is not active under an Long Term Care (LTC) aid code.

VI. Subacute Care Facility LTC Carve-In Policy Requirements

All Plan Letter 23-027: Subacute Care Facility LTC Benefit Standardization and Transition of Members to Managed Care

DHCS has released All Plan Letter 23-027 that outlines the requirements for implementing the Subacute Care Facility LTC benefit standardization and the transition of members to Medi-Cal managed care. DHCS has outlined the key requirements across the following domains:

I. Benefit Requirements
II. Network Readiness Requirements
III. Leave of Absence or Bed Hold Requirements
IV. Continuity of Care Requirements: Facility Payment
V. Continuity of Care Requirements: Medi-Cal Covered Services for Subacute Care Members with Existing Treatment Authorization Requests
VI. The Preadmission Screening and Resident Review
VII. Facility Payment
VIII. Payments for Medi-Cal Covered Services for Members Residing in a Subacute Care Facility
IX. Payment Processes Including Timely Payment of Claims
X. Population Health Management Requirements
XI. Long-Term Services and Supports Liaison
XII. MCP Quality Monitoring
XIII. Monitoring and Reporting
XIV. Policies and Procedures

VII. Policy Context for Promising Practices

While this document outlines promising practices within the APL domains from the SNF and Subacute Care Carve-Ins, it is important to highlight that all policy and requirements are detailed within the APL. The promising practices and model contract language represent lessons learned from the earlier CCI and COHS county implementation of transitioning LTC to managed care. DHCS recommends MCPs to consider the promising practices and the integration of the model contract language to inform provider contract amendments and/or for new provider contracts to support the SNF and Subacute Care provider network. MCPs, providers, and stakeholders should reference the APL to obtain a comprehensive understanding of the SNF and Subacute Care Carve-In requirements.

Rate Changes

The Long-Term Care Section of the Fee-for-Service Rates Development Division at DHCS conducts the annual study to develop the Medi-Cal rates for a variety of LTC providers. This section also conducts the necessary research to develop new or revised reimbursement methodologies necessary to meet changing policy or program needs.

The Medi-Cal LTC reimbursement rates are established under the authority of Title XIX of the federal Social Security Act. The specific methodology is described in the State Plan, a document prepared by DHCS staff which requires approval by the Centers for Medicare & Medicaid Services (CMS).

Table 5: Summary of SNF and Subacute Care Facility Payment Requirements

	SNF Payment Requirements	Subacute Care Payment Requirements
Newly Carved-In Counties	MCPs in counties where SNF services coverage is transitioning from the Medi-Cal FFS delivery system to the Medi-Cal managed care delivery system on January 1, 2023, must reimburse Network Providers of SNF services for those services at exactly the Medi-Cal FFS per-diem rates applicable to that particular type of institutional LTC provider, in	MCPs in counties where coverage of adult or pediatric subacute care services is newly transitioning from Medi-Cal FFS to Medi-Cal managed care on January 1, 2024, must reimburse Network Providers of adult or pediatric subacute care services for those services at exactly the applicable Medi-Cal FFS per diem rates, in accordance with W&I

	SNF Payment Requirements	Subacute Care Payment Requirements
	accordance with WIC Section 14184.201(b), APL 23-004, and the terms of the CMS-approved State directed payment preprint.	section 14184.201(c)(2), APL 23-027, and the terms of the CMS-approved State directed payment preprint.
	As stated in APL 23-004, this reimbursement requirement only applies to SNF services as defined in 22 CCR Sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a member's stay. The reimbursement requirement does not apply to any other services provided to a member receiving SNF services such as, but not limited to, services outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d), services provided by an Out-of-Network Provider of SNF services, or services that are not provided by a Network Provider of SNF services. Such non-qualifying services are not subject to the terms of this State directed payment and are payable by MCPs in accordance with terms negotiated between the MCP and the Provider. Medi-Cal FFS per-diem rates for SNF services are all-inclusive rates that account for both skilled and custodial	As stated in APL 23-027, this reimbursement requirement only applies to Subacute Care services as defined in 22 CCR Sections 51511, 51511.5, 51511.6, 51535, 51535.1, and 51215.7-51215.11. The reimbursement requirement does not apply to any other services provided to a member receiving adult or subacute care services such as, but not limited to, services provided by an Out-of-Network Provider or non-subacute care services. Such non-qualifying services are not subject to the terms of this State directed payment and are payable by MCPs in accordance with terms negotiated between the MCP and the Provider. Medi-Cal FFS per diem rates for adult subacute care services are all-inclusive rates differentiated between ventilator and non-

	SNF Payment Requirements	Subacute Care Payment Requirements
	levels of care and are not tiered according to the level of care.	ventilator accommodation codes. Medi-Cal FFS per diem rates for pediatric subacute care services are all-inclusive rates differentiated between ventilator, non-ventilator, ventilator weaning, and rehab therapy accommodation codes.
	See SNF FAQs for a list of included and excluded services.	See Subacute Care APL 23-027 for a list of included and excluded services.
Previously Carved-In Counties	MCPs in counties where SNF services are already Medi-Cal managed care Covered Services prior to January 1, 2023, must reimburse Network Providers of SNF services for those services at no less than the Medi-Cal FFS per-diem rates applicable to that particular type of institutional LTC provider.	MCPs in counties where adult or pediatric subacute care services are already Medi-Cal managed care Covered Services prior to January 1, 2024, must reimburse Network Providers of adult or pediatric subacute care services for those services at no less than the Medi-Cal FFS per diem rates applicable to that particular type of institutional LTC provider.

Prompt Claims and Payments

APL 23-020 provides an overview of MCPs' legal and contractual obligation to timely pay claims submitted by Providers for Covered Services to MCP Members.

MCPs must pay all claims within contractually mandated statutory timeframes and in accordance with the timely payment standards in the Contract for clean claims.

MCPs must pay claims, or any portion of any claim, as soon as practicable but no later than 30 days after receipt of the claim, and are subject to interest payments if failing to

meet the standards. DHCS expects MCPs to pay clean claims within 30 calendar days of receipt.

MCPs must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of receipt, and 99 percent of all clean claims from such practitioners' claims, within 90 days of the date of receipt. Please refer to APL 23-020, Requirements for Timely Payments of Claims, regarding requirements for MCPs related to timely payment of claims including Network Provider training requirements.

Electronic Claims Payments

MCPs must provide a process for Network Providers to submit electronic claims and to receive payment electronically if a Network Provider requests electronic processing. This must include, but not be limited to, processing automatic crossover payments for members who are dually eligible for Medicare and Medi-Cal. MCPs must also ensure that SNF and Subacute Care Facility staff have appropriate training on benefits coordination, including balanced billing prohibitions.

Leave of Absence and Bed Holds

Leaves of absence and bed holds are periods of time when a resident may leave the facility while retaining the ability to return, and the facility will continue to receive some payment. Medi-Cal requirements for bed hold and leave of absence are detailed in Title 22 CCR Sections 51535 and 51535.1. Additional guidance on payment and rules for bed holds and leaves of absence are available in the Medi-Cal Provider Manual. MCPs may require prior authorization for bed holds and leaves of absence.

Service Authorization Criteria

DHCS/MCP contract requires MCPs to follow specific state statute and guidelines for authorizing and covering SNF and Subacute Care Services:

- Contractor must authorize and cover SNF and Subacute Care services. Contractor must ensure that Members in need of SNF or Subacute Care services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, unless the Member has elected hospice care.
- Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6, the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334, Welfare and

Institutions Code (W&I) section 14132.25, and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

MCPs must implement a Population Health Management (PHM) Program that ensures all Medi-Cal managed care members, including those using SNF services, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), care management programs, and Community Supports. MCPs are subject to the PHM requirements outlined within the PHM Policy Guide, PHM APL, and Amended 2-23 MCP Contract.

Service Authorizations Timeline

DHCS/MCP contract includes specifics around authorization timeframes based on federal and state requirements, including:

- Routine Authorizations: Contractor must respond to routine requests as expeditiously as the Member's condition requires, but no longer than five business from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from the receipt of the request, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. Contractor may extend this deadline up to an additional 14 calendar days only if the Member or the Member's provider requests an extension or if Contractor justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 CFR section 438.210. Contractor must notify Member's provider and the Member in writing of any authorization request delayed beyond the five Working Day time frame, including the anticipated date on which a decision may be rendered, in accordance with H&S Code section 1367.01.
- Expedited Authorizations: Contractor must make expedited authorization decisions for service requests where a Member's provider indicates, or Contractor, Subcontractor, Downstream Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. Contractor must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after receipt of the request for services. Contractor may extend this deadline up to an additional 14 calendar days only if the Member or the

Member's provider requests an extension or if Contractor justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 CFR section 438.210. Contractor must notify Member's provider and the Member in writing of any authorization request delayed beyond the 72-hour time frame, including the anticipated date on which a decision may be rendered, in accordance with H&S Code section 1367.01. MCPs in all counties must expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to a Subacute Care Facility.

Network Readiness Requirements

As part of readiness, MCPs must develop sufficient Network capacity to enable timely member placement in facilities within 5 business days, 7 business days, or 14 calendar days of a request, depending on the county of residence, as outlined in W&I section 14197.

MCPs must ensure that if a member needs adult or pediatric subacute care services, they are placed in a health care facility that is under contract for subacute care with DHCS' SCU or is actively in the process of applying for a contract with DHCS' SCU. MCPs are not required to contract with facilities that do not have a current Medi-Cal Subacute Care Program contract or have not submitted an initial application to the Medi-Cal Subacute Care Program. The list of the currently contracted providers is available on the Medi-Cal Subacute website.

Table 6: Summary of SNF and Subacute Care Facility Network Readiness Requirements

SNFs	Subacute Care Facilities
Effective January 1, 2023, all MCPs were required to have and maintain an adequate network consisting of SNFs, licensed and certified by the CDPH, that provide medically necessary rehabilitative, restorative, and/or ongoing skilled nursing care to members in need of assistance with activities of daily living. DHCS is requiring MCPs to attempt to	MCPs must attempt to contract with all DHCS SCU contracted adult Subacute Care Facilities in the MCP's county and pediatric Subacute Care Facilities statewide and attest that they will meet timely access standards. MCPs must attempt contracting with facilities where their Medi-Cal members reside. » **Adult Subacute Care Facility Network Readiness Requirements**: MCPs must attempt to contract with all DHCS SCU

SNFs	Subacute Care Facilities
contract with all licensed SNFs in their area. All MCPs must comply with the SNF Network Readiness requirements outlined in the DHCS Skilled Nursing Facility Network Readiness Requirements.	contracted adult Subacute Care Facilities in the MCP's county. If there are insufficient facilities available within the MCP's county, MCP must attempt to contract with all Subacute Care facilities within the MCP's state region (Northern California, Central California, and Southern California). If the MCP does not have any available Subacute Care facilities within the State's region level, then the MCP must extend contracting efforts statewide. » **Pediatric Subacute Care Facility Network Readiness Requirements**: MCPs must attempt to contract with all DHCS SCU contracted pediatric Subacute Care Facilities (provided in both freestanding and hospital-based facilities) statewide. If a MCP cannot contract with all pediatric facilities statewide, the MCP must submit documentation indicating the reasons and provide explanations as to why the MCP was unable to secure a contract. All MCPs must comply with the SNF Network Readiness requirements outlined in the DHCS Subacute Care Facility Network Readiness Guide.

Medi-Cal Managed Care Plan Outreach and Engagement with SNFs

To ensure member access and continuity of care, MCPs will need to work closely with SNFs and Subacute Care Facilities to transition operations to Medi-Cal managed care and establish new partnerships and processes to support member needs. Two-way communication and joint transition planning between MCPs and facilities is required. Given the minimum number of facilities MCPs must contract with outlined within the

Network Readiness Requirements Guidance, MCPs are also required to outreach to all SNFs and Subacute Care Facilities to facilitate contracting and other policy development ahead of the transition.

MCP and facility communication and engagement are key to ensuring member access and continuity of care for members affected by the Carve-Ins.

Population Health Management Requirements

In addition to Benefit Standardization, effective January 1, 2023, MCPs must implement a PHM Program that ensures all Medi-Cal managed care members, including those using SNF or Subacute Care Services, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), care management programs, and Community Supports.

MCPs must, as a part of the PHM Program, provide strengthened transitional care services for all members across all settings and delivery systems to ensure that members are supported from discharge planning until they have been successfully connected to all needed services and supports. MCPs must ensure that a single point of contact, herein referred to as a care manager, can assist members throughout their transition and ensure all required services are complete. MCPs and their assigned care managers must ensure member transitions to and from a facility are timely and do not delay or interrupt any medically necessary services or care, and that all required transitional care activities are completed.

As part of Basic Population Health Management (BPHM), MCPs must ensure members are engaged with their assigned Primary Care Providers, including arranging transportation. MCPs must provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation to members, including those residing in a SNF or subacute care facility, in accordance with APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses, or any superseding APL.

For more information about PHM, please refer to the DHCS PHM Website at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

Long-Term Services and Supports (LTSS) Liaison

In order to address this challenge and support the overall transition of SNF services within Medi-Cal managed care, MCPs must establish an LTSS liaison role and ensuring facilities understand who their LTSS liaison is and how to communicate and partner with

them. The LTSS liaison is intended to serve as an MCP single point of contact for facilities and serve in both a provider representative and care coordination representative role. This individual or set of individuals can assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS provider community to best support a member's needs and their individualized care plans. To request the MCP specific LTSS Liaison in the county, please contact LTCTransition@dhcs.ca.gov.

VIII. SNF and Subacute Care Facility Carve-In Promising Practices and "Model" Contract Language

Medi-Cal Managed Care Plan Facility Outreach and Communications

Promising practices from counties where LTC services are already carved-in indicate that additional steps by MCPs and facilities can be helpful to ensure both are ready for a seamless transition. Note: MCPs are not required to incorporate "model" contract language into their standard model contract terms and conditions (unlike the requirement for ICF/DD Home contracts).

- **Internal Knowledge Building by MCPs**: For MCPs new to the SNF and/or Subacute Care Facility LTC benefit, it will be important to build internal capacity and familiarity ahead of the transition. This will include ensuring that all staff including call center staff understand the LTC benefit, and that staff in specific area have LTC specific knowledge including the ways LTC claims and payments may differ from other providers. Additionally, ensuring care management staff are familiar with this new population joining the MCP as well as the range of LTC and home- and community-based services (HCBS) and Community Supports available to members.
- **Innovative Communications**: MCPs and facilities have reported that it is important to invest in developing communications channels between MCPs and

facilities. During the CCI transition[11], some Cal MediConnect plans conducted "goodwill tours" and visited all facilities to begin developing relationships and lines of communications. It is helpful for MCPs to designate LTC-specific points of contact for facilities. For example, some MCPs in CCI counties created and maintained an updated list of health plan contacts for various needs (e.g., billing, member questions, and network decisions).

- **Proactive Integrated Transition Planning**: MCPs and facilities must meet ahead of the transition to conduct some joint planning for the transition. This may include:
    - **Identifying any potential continuity of care issues**: For medical supplies, transportation, or other Medi-Cal benefits not included in the per diem rate, facilities and MCPs should work together to proactively identify where facilities may be using providers or vendors not covered by the MCP so that all members have "day one" coverage of essential supplies and benefits.
    - **Community transitions**: MCPs should socialize with the SNFs and Subacute Care Facilities any policies and procedures with facilities around how the MCP will be using enhanced care management, community supports, or other care management services to identify members who may be able to transition to the community and how the facility will be engaged in that process.
    - **Providing Treatment Authorization Request (TAR) information**: Facilities are encouraged to collaborate with their members and members' authorized representatives to make their plan selections early. Once plan selections are made, facilities are encouraged to promptly communicate and provide the members' TAR information to the appropriate MCP. DHCS provided all MCPs with TAR data for current residents as part of the data exchange prior to January 1, 2024. The TAR data provided was at a point in time and intended to be used for planning purposes for the transition. The TAR data included approved TARs, not denied or pending TARs. MCPs can refer to the Plan Data Feed which is sent monthly to the MCPs and

[11] CCI counties include Los Angeles, Orange, Riverside, San Bernardino, San Mateo, San Diego, and Santa Clara.

includes data for active members, including TAR data. Further coordination between facilities and MCPs may be helpful to ensure accuracy and a seamless transition. A copy of the TAR form can be sent to the MCP through the LTSS Liaison.

Payment and Authorization Terms

Rate Changes

Facility payments in CCI counties were historically required to be no less than Medi-Cal FFS rates. MCPs were required to apply any changes in rates in Medi-Cal FFS to MCP contracted facilities.

APL 23-004 requires that MCPs pay timely, in accordance with the prompt payment standards within their contract. If, as the result of retroactive adjustments to the Medi-Cal FFS per-diem rates by DHCS, additional amounts that are owed in accordance with this APL and the terms of the CMS-approved State directed payment to a Network Provider of SNF services, then MCPs must make such adjustments timely. A promising practice is including contract language specifying the timing of retroactive rate changes given that some facilities have reported challenges or delays in receiving updated rates from MCPs.

"Model" Contract Language

For counties where coverage of SNF services newly transitioned from the FFS delivery system to the managed care delivery system on January 1, 2023 only:

SNF*: MCP must pay Facility for authorized Per Diem Services in accordance with APL 23-004. MCP will adopt and pay DHCS' published per diem rates. Excluded Covered Services are not subject to the per diem rates and are negotiated between the MCP and Facility. If, as the result of retroactive adjustments to the Medi-Cal FFS per diem rates by DHCS, additional amounts are owed in accordance with the terms of APL 23-004 to the Facility, then the MCP will make such adjustments as soon as practicable, but no later than 30 calendar days after the receipt of the claim by the health care service plan. A Facility accepts the applicable prevailing per diem rates as published by DHCS, as payment in full in accordance with the Medi-Cal Provider Manual.*

For counties where coverage of Subacute Care services newly transitioned from the FFS delivery system to the managed care delivery system on January 1, 2024 only:

***Subacute Care Facility**: MCP must pay Subacute Care Facility for authorized Per Diem Services in accordance with APL 23-027. MCP will adopt and pay DHCS' published per diem rates. Excluded Covered Services are not subject to the per diem rates and are negotiated between the MCP and Subacute Care Facility. If, as the result of retroactive adjustments to the Medi-Cal FFS per diem rates by DHCS, additional amounts are owed in accordance with the terms of APL 23-027 to the Subacute Care Facility, then the MCP will make such adjustments as soon as practicable, but no later than 30 calendar days after the receipt of the claim by the health care service plan. A Subacute Care Facility accepts the applicable prevailing per diem rates as published by DHCS, as payment in full in accordance with the Medi-Cal Provider Manual.*

For counties where coverage of SNF services were already covered in the Medi-Cal managed care delivery system prior to January 1, 2023.

***SNF**: MCP must pay Facility for authorized Per Diem Services in accordance with APL 23-004. MCP will adopt and pay no less than DHCS' published per diem rates. Excluded Covered Services are not subject to the per diem rates and are negotiated between the MCP and Facility. If, as the result of retroactive adjustments to the Medi-Cal FFS per diem rates by DHCS, additional amounts are owed in accordance with the terms of APL 23-004 to the Facility, then the MCP will make such adjustments as soon as practicable, but no later than 30 calendar days after the receipt of the claim by the health care service plan. A Facility accepts the applicable prevailing per diem rates as published by DHCS, as payment in full in accordance with the Medi-Cal Provider Manual.*

For counties where coverage of Subacute Care services were already covered in the Medi-Cal managed care delivery system prior to January 1, 2024.

***Subacute Care Facility**: MCP must pay Subacute Care Facility for authorized Per Diem Services in accordance with APL 23-027. MCP will adopt and pay no less than DHCS' published per diem rates. Excluded Covered Services are not subject to the per diem rates and are negotiated between the MCP and Subacute Care Facility. If, as the result of retroactive adjustments to the Medi-Cal FFS per diem rates by DHCS, additional amounts are owed in accordance with the terms of APL 23-027 to the Subacute Care Facility, then the MCP will make such adjustments as soon as practicable, but no later than 30 calendar days after the receipt of the claim by the health care service plan. A Subacute Care Facility accepts the applicable prevailing per diem rates as published by DHCS, as payment in full in accordance with the Medi-Cal Provider Manual.*

Prompt Claims and Payment

SNF and Subacute Care Facilities often do not have the same financial reserves or diverse payer mix as other types of providers and rely on prompt payment from Medi-Cal FFS and MCPs. Additionally, MCPs and facilities have reported issues with facilities being able to submit clean claims in a timely manner. When MCPs are able to offer shorter payment timeframes for clean claims, that may help support provider operations. When possible, a promising practice is to expedite payments to LTC facilities. MCPs are encouraged to promptly enter each member into their system to further ensure efficient payment processing. MCPs are also encouraged to enter each facility into their claims system to ensure prompt payment processes.

Additionally, SNF and Subacute Care Facilities benefit from outreach, education, and support from MCPs to understand how to submit clean claims and to meet clean claims requirements. See below for more information on how standardized billing codes and other administrative simplifications may also be able to help this issue.

> ***"Model" Contract Language***
>
> ***SNF/Subacute Care Facility****: MCPs must pay the Facility for Per Diem Services provided to Members when Claims are submitted in accordance with this Contract, MCP policies, and when MCP authorized the Member's admission or continued residency. In accordance with the DHCS Contract, MCPs are required to pay at least 90% of Clean Claims within 30 calendar days of receipt, and 99% of all Clean Claims within 90 calendar days. MCPs are highly encouraged to pay claims and invoices at the same frequency in which they are received, whether electronic or paper claims.*
>
> *MCPs must provide outreach, education, and support to Facilities to understand how to submit Clean Claims and to meet Clean Claims requirements.*
>
> *MCPs must identify an individual or set of individuals to serve as a Long-Term Services and Supports (LTSS) liaison for the Facilities. The LTSS liaison must provide support to the Facilities both in a Provider representative role and to support care transitions, as needed.*

Electronic Claims Payments

MCPs in CCI counties have been able to accept and pay electronic claims. Those plans who process claims manually are more likely to make errors, pay random claims out of sequence and create more work for the provider. APL 23-004 requires MCPs to provide a process for Network Providers to submit electronic claims and to receive payment

electronically if a Network Provider requests electronic processing including, but not limited to, processing automatic crossover payments for members who are dually eligible for Medicare and Medi-Cal. MCPs must provide clear instructions on electronic claims processing systems to reduce errors and associated payment delays. MCPs must also provide a clear explanation of the claims appeals process.

> ***"Model" Contract Language***
>
> ***SNF/Subacute Care Facility****: MCPs must provide education and training for their Network Providers on their billing/Claims processes including appeals processes. MCPs must make this available to their Facility providers.*
>
> *The Facility must submit Claims for Per Diem Services in accordance with MCP Policies. Claims may be submitted electronically to the MCP. If the Facility chooses to electronically submit Claims, the Facility must complete a process agreed upon by the Facility and the MCP. If the Facility chooses to receive payment electronically, the Facility must complete an Electronic Fund Transfer ("EFT") Authorization Form.*

Leave of Absence and Bed Holds

Clear communication about payment and payment timelines for leave of absences and bed holds help support facilities' compliance with these requirements and support smooth transitions for members. Leave of absence and bed hold policies are often new to MCPs taking on the SNF/Subacute Care benefit. A promising practice is to have MCP authorization policies for bed holds and leave of absences stated in the provider/MCP contract. The MCP and facility should communicate often about how to timely and accurately request authorizations or documentation needed for reimbursement when prior authorization is not needed. The MCP must also ensure that internal plan staff including provider relations staff and claims and billing staff have specific knowledge regarding the leave of absence and bed hold LTC-specific benefit.

> ***"Model" Contract Language***
>
> ***SNF/Subacute Care Facility****: The MCPs must include as a covered benefit any leave of absence Facility provides in accordance with the requirements of Title 22, California Code of Regulations (CCR) Sections 51535. The MCP must approve up to 73 LOA days per calendar year. The MCP must also include as a covered benefit any bed hold a Facility provides in accordance with the requirements of 22 CCR Section 51535.1.*

Care Management

Service Authorization Criteria

MCPs new to covering SNF/Subacute Care are not experienced with LTC authorization criteria and are required to build existing requirements into their utilization management policies and procedures. A promising practice is to include in the MCP/facility contract references the guiding statutes and regulations. Consistent and continuous communication ensures both parties are operating from the same rule book.

As MCPs are developing their utilization management policies and procedures, they are required to consider how a person-centered approach should consider input and evidence of medical need for a particular SNF/Subacute Care level of care from members, their responsible family members/guardians, or authorized representatives. The plan of care should include evidence of care needs from treating physicians, home caregivers, and/or family members.

Upon a member's transition to a new care setting or back to their home or community, DHCS MCPs are required to follow up with the member or their caregivers, family members/guardians, or authorized representations (if permitted by the member) or the facility. A best practice is conducting a minimum of three attempts to confirm a member's needs are being met in a new setting within the first 30 days. Additionally, MCPs should also document the outcome of each attempt within their care management system in the member's record.

An additional promising practice as part of the authorization process, MCPs should share with facilities the facility member placement acceptance criteria that helps ensure equitable placement of members at the appropriate level of care.

"Model" Contract Language

SNF/Subacute Care Facility*: MCP's <UM or other applicable office> shall be responsible for all determinations of approval or denial of a Member's admission to and/or extended stay at Facility. As part of such review, MCP shall certify the medical necessity of institutional care consistent with the Medi-Cal Manual of Criteria and as defined in Title 22, CCR sections 51224.5, 51224.6, 51335, 51335.5, 51335.6, and 51334, Welfare & Institutions Code section 14132.25, the California Department of Health Care Services (DHCS) Long Term Care (LTC) Provider Manual, and further defined in MCP's <Provider Manual or relevant document>.*

Service Authorizations Timeline

SNF Authorizations

Transition to an appropriate level of care without delay is important for optimal patient outcomes and avoiding unnecessary hospital costs. DHCS provides detail on how SNF and Subacute Care authorization requests are handled in Medi-Cal FFS through the Medi-Cal Provider Manual and Long Term Care Treatment Authorization Request (LTC TAR form 20-1). While MCPs are not required to follow the provider manual, it may be a useful reference for MCPs in developing policies and procedures.

Subacute Care Authorizations

Effective January 1, 2024, for members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, MCPs are responsible for covering treatment authorization requests (TARs) that are approved by DHCS for up to 3, 6, or 12 months, depending on the type of TAR. DHCS provides detail on how LTC authorization requests are handled in Med-Cal FFS through the Medi-Cal Provider Manual as well as Information for Authorization/Reauthorization of Subacute Care Services - Adult Subacute Program (DHCS form 6200) and Information for Authorization/Reauthorization of Subacute Care Services - Pediatric Subacute Program (DHCS form 6200A). While MCPs are not required to follow the provider manual, it may be a useful reference for MCPs in developing policies and procedures.

Table 7: Summary of Subacute Care TAR Requirements by TAR Type

TAR Category	Continuity of Care Requirements for Existing TARs	Reauthorization
Adult/Pediatric Subacute Care Services Under Per Diem Rate	MCPs are responsible for covering services in TARs approved by DHCS for six (6) months after enrollment in the MCP, or for the duration of the TAR, whichever is shorter.	MCPs may approve reauthorizations for up to 6 months, or up to one year for members who have been identified/meet the criteria of prolonged care.

TAR Category	Continuity of Care Requirements for Existing TARs	Reauthorization
Adult Subacute Care Services Outside Per Diem Rate and Pediatric Subacute Services Outside Per Diem Rate (except for supplemental rehabilitation therapy service and ventilator weaning services)	MCPs are responsible for covering all other services in TARs approved by DHCS exclusive of the per diem rate for six (6) months after enrollment in the MCP, or for the duration of the TAR, whichever is shorter.	MCPs may approve reauthorizations for up to six (6) months, or up to one year for members who have been identified/meet the criteria of prolonged care.
Pediatric Supplemental Rehabilitation Therapy Service and Ventilator Weaning Services	MCPs are responsible for covering supplemental rehabilitation therapy services and ventilator weaning services for TARs approved by DHCS for three (3) months after enrollment in the MCP.	MCPs may approve reauthorizations for up to three (3) months.

There may also be instances in which an expedited authorization is needed. Per 42 CFR section 438.10 and H&S section 1367.01, an expedited authorization decision may be needed in cases in which following the standard timeframe for Prior Authorizations could seriously jeopardize the member's life, health, or ability to maintain or regain maximum function. MCPs must provide its authorization decision as expeditiously as the member's health condition requires but no longer than 72 hours after the MCP's receipt of the request for services. MCPs should communicate requests for supporting documentation in a timely manner and facilitate communication with the facility regarding a change in the member's status. The MCP and facility should work together to ensure that the member's needs are met, especially before, during, and after a Leave of Absence or Bed Hold.

Promising practices have identified areas that MCPs and facilities may want to use contracts or policies and procedures to ensure clarity and smooth authorization processes including:

- Easily understandable and readily available descriptions of the authorization request process and timeframe for LTC services.
- Ensuring staff at facilities have clear understandings of timing and processes to request reauthorization for a resident whose existing authorization is nearing the end date.
- Reminding SNFs/Subacute Care Facilities that members can request an additional 12 months of Continuity of Care following the initial Continuity of Care period.
- Developing clear, specific, and available MCP escalation contacts for facilities and and/or members to escalate concerns when there are delays in pending authorizations.
- Creating and sharing retroactive authorization policies that allow providers more time to submit authorization requests.

"Model" Contract Language

***SNF**: An initial Long Term Care Treatment Authorization Request must be required for each Skilled Nursing Facility admission. An initial Authorization may be granted for periods up to two years from the date of admission. The MCP reserves the right to initiate review of the need for the continued level of care and to reauthorize the services more frequently. An approved initial authorization is required prior to transfer of members between Skilled Nursing Facilities. A request for reauthorization must be received by the MCP on or before the first working day following the expiration of a current authorization. Reauthorizations may be granted for up to two years.*

The MCP must inform the Facility of its authorization protocols including:

▪ *Making the authorization request process and timeframes easily understandable and readily available; and*

▪ *Developing clear, specific, and available MCP escalation contacts for Facilities and/or members to escalate concerns when there are delays in pending authorizations, including providing the LTSS Liaison contact.*

***Subacute Care Facility**: An initial Long Term Care Treatment Authorization Request must be required for each Subacute Care Facility admission. An initial Authorization may be granted for periods up to three, six, or twelve months, depending on the type of TAR, from the date of admission. The MCP reserves the right to initiate review of the need for the continued level of care and to reauthorize the services more frequently.*

An approved initial TAR is required prior to transfer of members between Subacute Care Facilities. A request for reauthorization must be received by the MCP on or before the first working day following the expiration of a current authorization. Reauthorizations may be granted for up to three, six, or twelve months, depending on the type of TAR.

The MCP must inform the Facility of its authorization protocols including:

▪ *Making the authorization request process and timeframes easily understandable and readily available; and*

▪ *Developing clear, specific, and available MCP escalation contacts for Facilities and/or members to escalate concerns when there are delays in pending authorizations, including providing the LTSS Liaison contact.*

IX. Appendices: LTC Carve-In by Type, County, and MCP

Appendix Table A: SNF Carve-In by County and Plan

County	SNF Carve-In on 1/1/23	2023 MCPs	2024 MCPs
Alameda	x	Anthem Blue Cross Partnership Plan	Alameda Alliance for Health
		Alameda Alliance for Health	Kaiser Permanente
Alpine	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		California Health & Wellness	Mountain Valley Health Plan
Amador	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		California Health & Wellness	Health Net Community Solutions Inc.
		Kaiser Permanente	Kaiser Permanente
Butte	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	
Calaveras	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		California Health & Wellness	Health Net Community Solutions Inc.
Colusa	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	
Contra Costa	x	Anthem Blue Cross Partnership Plan	Contra Costa Health Plan
		Contra Costa Health Plan	Kaiser Permanente
Del Norte		Partnership Health Plan of California	Partnership Health Plan of California
El Dorado	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		California Health & Wellness	Mountain Valley Health Plan
		Kaiser Permanente	Kaiser Permanente
Fresno	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan

County	SNF Carve-In on 1/1/23	2023 MCPs	2024 MCPs
		CalViva Health	CalViva Health
			Kaiser Permanente
Glenn	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	
Humboldt		Partnership Health Plan of California	Partnership Health Plan of California
Imperial	x	California Health & Wellness	Community Health Plan of Imperial Valley
		Molina Healthcare of California	Kaiser Permanente
Inyo	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		California Health & Wellness	Health Net Community Solutions Inc.
Kern	x	Health Net Community Solutions Inc.	Anthem Blue Cross Partnership Plan
		Kern Family Health Care	Kern Family Health Care Kaiser Permanente
Kings	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		CalViva Health	CalViva Health
			Kaiser Permanente
Lake		Partnership Health Plan of California	Partnership Health Plan of California
Lassen		Partnership Health Plan of California	Partnership Health Plan of California
Los Angeles		Health Net Community Solutions Inc.	Health Net Community Solutions Inc.
			Molina Healthcare of California
			L.A. Care Health Plan
		L.A. Care Health Plan	Kaiser Permanente
			Positive Healthcare Foundation
			SCAN Health Plan
Madera	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan

County	SNF Carve-In on 1/1/23	2023 MCPs	2024 MCPs
		CalViva Health	CalViva Health
			Kaiser Permanente
Marin		Partnership Health Plan of California	Partnership Health Plan of California
			Kaiser Permanente
Mariposa	x	Anthem Blue Cross Partnership Plan	Central California Alliance for Health
		California Health & Wellness	Kaiser Permanente
Mendocino		Partnership Health Plan of California	Partnership Health Plan of California
Merced		Central California Alliance for Health	Central California Alliance for Health
Modoc		Partnership Health Plan of California	Partnership Health Plan of California
Mono	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		California Health & Wellness	Health Net Community Solutions Inc.
Monterey		Central California Alliance for Health	Central California Alliance for Health
Napa		Partnership Health Plan of California	Partnership Health Plan of California
			Kaiser Permanente
Nevada	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	
Orange		CalOptima Health	CalOptima Health
			Kaiser Permanente
Placer	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	
		Kaiser Permanente	Kaiser Permanente
Plumas	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	
Riverside		Molina Healthcare of California	Molina Healthcare of California
		Inland Empire Health Plan	Inland Empire Health Plan

County	SNF Carve-In on 1/1/23	2023 MCPs	2024 MCPs
			Kaiser Permanente
			SCAN Health Plan
Sacramento	x	Aetna Better Health of California	Anthem Blue Cross Partnership Plan
		Anthem Blue Cross Partnership Plan	Health Net Community Solutions Inc.
		Health Net Community Solutions Inc.	Molina Healthcare of California
		Molina Healthcare of California	Kaiser Permanente
		Kaiser Permanente	
San Benito	x	Anthem Blue Cross Partnership Plan	Central California Alliance for Health
		Medi-Cal Fee For Service	
San Bernadino		Molina Healthcare of California	Molina Healthcare of California
		Inland Empire Health Plan	Inland Empire Health Plan
			Kaiser Permanente
			SCAN Health Plan
San Diego		Aetna Better Health of California	Blue Shield of California Promise Health Plan
		Blue Shield of California Promise Health Plan	
		Community Health Group Partnership	Community Health Group Partnership
		Health Net Community Solutions Inc.	
		Kaiser Permanente	Kaiser Permanente
		Molina Healthcare of California	Molina Healthcare of California
			SCAN Health Plan
San Francisco	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		San Francisco Health Plan	San Francisco Health Plan
			Kaiser Permanente
San Joaquin	x	Health Net Community Solutions Inc.	Health Net Community Solutions Inc.
		Health Plan San Joaquin	Health Plan San Joaquin
			Kaiser Permanente

County	SNF Carve-In on 1/1/23	2023 MCPs	2024 MCPs
San Luis Obispo		CenCal Health	CenCal Health
San Mateo		Health Plan of San Matero	Health Plan of San Mateo
			Kaiser Permanente
Santa Barbara		CenCal Health	CenCal Health
Santa Clara		Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		Santa Clara Family Health Plan	Santa Clara Family Health Plan
			Kaiser Permanente
Santa Cruz		Central California Alliance for Health	Central California Alliance for Health
			Kaiser Permanente
Shasta		Partnership Health Plan of California	Partnership Health Plan of California
Sierra	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	
Siskiyou		Partnership Health Plan of California	Partnership Health Plan of California
Solano		Partnership Health Plan of California	Partnership Health Plan of California
			Kaiser Permanente
Sonoma		Partnership Health Plan of California	Partnership Health Plan of California
			Kaiser Permanente
Stanislaus	x	Health Net Community Solutions Inc.	Health Net Community Solutions Inc.
		Health Plan of San Joaquin	Health Plan of San Joaquin
			Kaiser Permanente
Sutter	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	Kaiser Permanente
Tehama	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	
Trinity		Partnership Health Plan of California	Partnership Health Plan of California

County	SNF Carve-In on 1/1/23	2023 MCPs	2024 MCPs
Tulare	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		Health Net Community Solutions Inc.	Health Net Community Solutions Inc.
			Kaiser Permanente
Tuolumne	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
		California Health & Wellness	Health Net Community Solutions Inc.
Ventura		Gold Coast Health Plan	Gold Coast Health Plan
			Kaiser Permanente
Yolo		Partnership Health Plan of California	Partnership Health Plan of California
			Kaiser Permanente
Yuba	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
		California Health & Wellness	Kaiser Permanente

- * Indicates that MCPs will authorize and cover Medically Necessary SNF services starting 1/1/23. Currently, these MCPs cover Medically Necessary SNF services for members from the time of admission into a Subacute Care Facility and up to one month after the month of admission. Counties that do not have an X are those that currently provide coverage for SNF services under the institutional LTC services benefit.
- For more information on MCPs by county, please see the Medi-Cal Managed Care Health Plan Directory.

Appendix Table B: Subacute Care Carve-In by County and Plan

County	Adult Subacute Carve-In on 1/1/24*	Pediatric Subacute Carve-In on 1/1/24*	2023 MCPs	2024 MCPs
Alameda	x	x	Anthem Blue Cross Partnership Plan	Alameda Alliance for Health
			Alameda Alliance for Health	Kaiser Permanente
Alpine	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			California Health & Wellness	Mountain Valley Health Plan
Amador	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			California Health & Wellness	Health Net Community Solutions Inc.
			Kaiser Permanente	Kaiser Permanente
Butte	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	
Calaveras	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			California Health & Wellness	Health Net Community Solutions Inc.
Colusa	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	
Contra Costa	x	x	Anthem Blue Cross Partnership Plan	Contra Costa Health Plan

County	Adult Subacute Carve-In on 1/1/24*	Pediatric Subacute Carve-In on 1/1/24*	2023 MCPs	2024 MCPs
			Contra Costa Health Plan	Kaiser Permanente
Del Norte			Partnership Health Plan of California	Partnership Health Plan of California
El Dorado	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			California Health & Wellness	Mountain Valley Health Plan
			Kaiser Permanente	Kaiser Permanente
Fresno	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			CalViva Health	CalViva Health
				Kaiser Permanente
Glenn	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	
Humboldt			Partnership Health Plan of California	Partnership Health Plan of California
Imperial	x	x	California Health & Wellness	Community Health Plan of Imperial Valley
			Molina Healthcare of California	Kaiser Permanente
Inyo	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			California Health & Wellness	Health Net Community Solutions Inc.
Kern	x	x	Health Net Community Solutions Inc.	Anthem Blue Cross Partnership Plan
			Kern Family Health Care	Kern Family Health Care

County	Adult Subacute Carve-In on 1/1/24*	Pediatric Subacute Carve-In on 1/1/24*	2023 MCPs	2024 MCPs
				Kaiser Permanente
Kings	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			CalViva Health	CalViva Health
				Kaiser Permanente
Lake			Partnership Health Plan of California	Partnership Health Plan of California
Lassen			Partnership Health Plan of California	Partnership Health Plan of California
Los Angeles		x	Health Net Community Solutions Inc.	Health Net Community Solutions Inc.
				Molina Healthcare of California
				L.A. Care Health Plan
			L.A. Care Health Plan	Kaiser Permanente
				SCAN Health Plan
				Positive Healthcare Foundation
Madera	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			CalViva Health	CalViva Health
				Kaiser Permanente
Marin			Partnership Health Plan of California	Partnership Health Plan of California
				Kaiser Permanente
Mariposa	x	x	Anthem Blue Cross Partnership Plan	Central California Alliance for Health

County	Adult Subacute Carve-In on 1/1/24*	Pediatric Subacute Carve-In on 1/1/24*	2023 MCPs	2024 MCPs
			California Health & Wellness	Kaiser Permanente
Mendocino			Partnership Health Plan of California	Partnership Health Plan of California
Merced			Central California Alliance for Health	Central California Alliance for Health
Modoc			Partnership Health Plan of California	Partnership Health Plan of California
Mono	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			California Health & Wellness	Health Net Community Solutions Inc.
Monterey			Central California Alliance for Health	Central California Alliance for Health
Napa			Partnership Health Plan of California	Partnership Health Plan of California
				Kaiser Permanente
Nevada	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	
Orange			CalOptima Health	CalOptima Health
				Kaiser Permanente
Placer	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	
			Kaiser Permanente	Kaiser Permanente

County	Adult Subacute Carve-In on 1/1/24*	Pediatric Subacute Carve-In on 1/1/24*	2023 MCPs	2024 MCPs
Plumas	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	
Riverside		x	Molina Healthcare of California	Molina Healthcare of California
			Inland Empire Health Plan	Inland Empire Health Plan
				Kaiser Permanente
				SCAN Health Plan
Sacramento	x	x	Aetna Better Health of California	Anthem Blue Cross Partnership Plan
			Anthem Blue Cross Partnership Plan	Health Net Community Solutions Inc.
			Health Net Community Solutions Inc.	Molina Healthcare of California
			Molina Healthcare of California	Kaiser Permanente
			Kaiser Permanente	
San Benito	x	x	Anthem Blue Cross Partnership Plan	Central California Alliance for Health
			Medi-Cal Fee For Service	
San Bernadino		x	Molina Healthcare of California	Molina Healthcare of California
			Inland Empire Health Plan	Inland Empire Health Plan
				Kaiser Permanente
				SCAN Health Plan

County	Adult Subacute Carve-In on 1/1/24*	Pediatric Subacute Carve-In on 1/1/24*	2023 MCPs	2024 MCPs
San Diego		x	Aetna Better Health of California	Blue Shield of California Promise Health Plan
			Blue Shield of California Promise Health Plan	
			Community Health Group Partnership	Community Health Group Partnership
			Health Net Community Solutions Inc.	
			Kaiser Permanente	Kaiser Permanente
			Molina Healthcare of California	Molina Healthcare of California
				SCAN Health Plan
San Francisco	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			San Francisco Health Plan	San Francisco Health Plan
				Kaiser Permanente
San Joaquin	x	x	Health Net Community Solutions Inc.	Health Net Community Solutions Inc.
			Health Plan San Joaquin	Health Plan San Joaquin
				Kaiser Permanente
San Luis Obispo			CenCal Health	CenCal Health
San Mateo			Health Plan of San Matero	Health Plan of San Mateo
				Kaiser Permanente
Santa Barbara			CenCal Health	CenCal Health
Santa Clara		x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan

County	Adult Subacute Carve-In on 1/1/24*	Pediatric Subacute Carve-In on 1/1/24*	2023 MCPs	2024 MCPs
			Santa Clara Family Health Plan	Santa Clara Family Health Plan
				Kaiser Permanente
Santa Cruz	x	x	Central California Alliance for Health	Central California Alliance for Health
				Kaiser Permanente
Shasta			Partnership Health Plan of California	Partnership Health Plan of California
Sierra	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	
Siskiyou			Partnership Health Plan of California	Partnership Health Plan of California
Solano			Partnership Health Plan of California	Partnership Health Plan of California
				Kaiser Permanente
Sonoma			Partnership Health Plan of California	Partnership Health Plan of California
				Kaiser Permanente
Stanislaus	x	x	Health Net Community Solutions Inc.	Health Net Community Solutions Inc.
			Health Plan of San Joaquin	Health Plan of San Joaquin
				Kaiser Permanente
Sutter	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California

County	Adult Subacute Carve-In on 1/1/24*	Pediatric Subacute Carve-In on 1/1/24*	2023 MCPs	2024 MCPs
			California Health & Wellness	Kaiser Permanente
Tehama	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	
Trinity	x	x	Partnership Health Plan of California	Partnership Health Plan of California
Tulare	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			Health Net Community Solutions Inc.	Health Net Community Solutions Inc.
				Kaiser Permanente
Tuolumne	x	x	Anthem Blue Cross Partnership Plan	Anthem Blue Cross Partnership Plan
			California Health & Wellness	Health Net Community Solutions Inc.
Ventura			Gold Coast Health Plan	Gold Coast Health Plan
				Kaiser Permanente
Yolo			Partnership Health Plan of California	Partnership Health Plan of California
				Kaiser Permanente
Yuba	x	x	Anthem Blue Cross Partnership Plan	Partnership Health Plan of California
			California Health & Wellness	Kaiser Permanente

» * Indicates that MCPs will authorize and cover Medically Necessary adult and/or pediatric care services starting 1/1/24. Currently, these MCPs cover Medically Necessary adult subacute services and/or pediatric subacute care services for

members from the time of admission into a Subacute Care Facility and up to one month after the month of admission. Counties that do not have an X are those that currently provide coverage for adult and/or pediatric subacute services under the institutional LTC services benefit.

» For more information on MCPs by county, please see the Medi-Cal Managed Care Health Plan Directory.

Appendix Table C: Pediatric Subacute Care Carve-In Changes Table

The following table provides a high-level overview of the changes between coverage of Pediatric Subacute Care services in Fee-For-Service, the current state in 31 counties, and Medi-Cal Managed Care.

Policy Area	Pediatric Subacute Care: FFS	Pediatric Subacute Care: Managed Care	Key Highlights
Medical Necessity Criteria	Consistent with definitions in 22 Code of California Regulations (CCR) section 51124.6, Welfare and Institutions Code (W&I) section 14132.25, and the Medi-Cal Manual of Criteria.	Consistent with definitions in 22 Code of California Regulations (CCR) section 51124.6, Welfare and Institutions Code (W&I) section 14132.25, and the Medi-Cal Manual of Criteria.	No change; plans may supplement criteria as they see fit but may not make changes to the existing Medical Necessity Criteria.
Initial Service Authorization	Submit TAR to DHCS for services and a completed: » Information for Authorization/Reauthorization of Subacute Care Services – Pediatric Subacute Program (DHCS form 6200). Information for Authorization/Reauthorization of Subacute Care Services - Pediatric Subacute Program. » DHCS form 6170 Preadmission Screening	Submit TAR to MCP for services. MCPs may require specific authorization/reauthorization forms.	A completed DHCS form 6170 (PASRR) must also be submitted with any TAR requesting subacute level of care. Pediatric Supplemental Services, including Supplemental Rehabilitation Therapy Services and Ventilator Weaning Services require a separate TAR be submitted. Initial TARs for Supplemental Rehabilitation Therapy Services and Ventilator Weaning Services are authorized in accordance with the following:

Policy Area	Pediatric Subacute Care: FFS	Pediatric Subacute Care: Managed Care	Key Highlights
	and Resident Review (PASRR) must be completed online and submitted with initial TARs requesting subacute level of care (LOC). Refer to the PASRR process found in the Medi-Cal Provider Manual – PASRR. » Medical Doctor (MD) order for admission to subacute facility. Pediatric Subacute initial authorization requests may be approved for periods of up to six months, as specified in CCR, Title 22, Section 51335.6(c).		» Supplemental Rehabilitation Therapy Service TARs must meet requirements specified in CCR, Title 22, Section 51215.10 and the Medi-Cal Provider Manual – Subacute Care Programs: Pediatric. » Ventilator Weaning Service TARs must meet requirements specified in CCR, Title 22, Section 51215.11 and the Medi-Cal Provider Manual – Subacute Care Programs: Pediatric. Supplemental Rehabilitation Therapy Service and Ventilator Weaning Service TARs may be approved for a maximum period of three months.
Service Reauthorization	To request authorization for subacute services, providers submit Long Term Care Treatment Authorization Requests (20-1) and state in Section C that the level of care is	Providers will submit forms and documentation required by the MCPs.	Reauthorization TARs for Supplemental Rehabilitation Therapy Services and Ventilator Weaning Services are authorized in accordance with the following:

Policy Area	Pediatric Subacute Care: FFS	Pediatric Subacute Care: Managed Care	Key Highlights
	subacute. Subacute facilities submit the appropriate DHCS 6200 in lieu of MDS 3.0. Submit TAR to DHCS for services and a completed: » Information for Authorization/Reauthorization of Subacute Care Services – Pediatric Subacute Program (DHCS form 6200) Provide the following clinical documentation: » A detailed summary of acute care hospitalizations for this member during the previous authorization period; » A copy of weekly MD progress notes covering the month prior to TAR submission;		» Supplemental Rehabilitation Therapy Service TARs must meet requirements specified in CCR, Title 22, Section 51215.10 and the Medi-Cal Provider Manual – Subacute Care Programs: Pediatric. » Ventilator Weaning Service TARs must meet requirements specified in CCR, Title 22, Section 51215.11 and the Medi-Cal Provider Manual – Subacute Care Programs: Pediatric. Subsequent Supplemental Rehabilitation Therapy Service and Ventilator Weaning Service reauthorization TARs may be approved for a maximum period of three months.

Policy Area	Pediatric Subacute Care: FFS	Pediatric Subacute Care: Managed Care	Key Highlights
	» A copy of the notes from the most recent discharge planning conference. Subacute reauthorization for adult and pediatric may be approved for periods of up to six months, as specified in CCR, Title 22, Sections 51335.5(c) and 51335.6(c). Consistent with APL 23-027, reauthorizations may be approved for one year for members who have been identified or meet the criteria of "prolonged care." Prolonged Care classification specified in the Medi-Cal Manual of Criteria R-15-98E, recognizes that the medical condition of selected members requires a prolonged period of skilled nursing care.		
Subacute Service Codes and Billing Form	Physicians bill for subacute services on the CMS-1500 by specifying the appropriate Place	Providers will submit claims to MCPs for payment using National Uniform Billing Committee	Previously, subacute care providers bill subacute services on the *Payment Request for Long Term*

Policy Area	Pediatric Subacute Care: FFS	Pediatric Subacute Care: Managed Care	Key Highlights
	of Service, modifier U2, and billing codes listed in the Subacute Care Programs: Billing Codes section in the appropriate Part 2 manual.	(NUBC)/Health Insurance Portability and Accountability Act (HIPAA) compliant code sets. Facilities will have the option to submit claims digitally.	*Care* 25-1 form. They are transitioning to National Uniform Billing Committee (NUBC) UB-04 effective February 1, 2024.
TAR Approval	DHCS Clinical Assurance Division (CAD) currently approve TARs for pediatric subacute level of care in accordance with CCR, Title 22, Sections 51124.6, 51335.6, 51511.6, and Welfare and Institutions Code (WIC) Section 14132.25(e) and (f). Additional criteria includes the following, as specified in the Medi-Cal Provider Manual – Subacute Care Programs: Pediatric Authorization shall be based on medical necessity and the lowest cost service in accordance with CCR, Title 22, Sections 51003 and 51303.	The MCPs will review Prior Authorizations after January 1, 2024, and will notify the facilities of approval.	

Policy Area	Pediatric Subacute Care: FFS	Pediatric Subacute Care: Managed Care	Key Highlights
TAR Denial	CAD notifies the facilities in real time of any denials or modifications. TARs may be denied due to not meeting medical necessity and/or Medi-Cal policy for Pediatric Subacute LOC.	The MCP will review the TARs and notify the facilities of any denials.	
Credentialing/ Contracting	Responsibility of SCU	Responsibility of SCU.	
LOAs/Bed Holds	Medi-Cal must ensure the provision of a leave of absence (LOA)/bed hold by a Subacute Care Facility in accordance with the requirements of 22 CCR section 72520 and California's Medicaid State Plan. Medi-Cal must allow the member to return to the same Subacute Care Facility where they previously resided under the LOA/bed hold policies subject to Medical Necessity in accordance with the Medi-Cal requirements for LOA and bed hold, which are detailed in 22 CCR sections	MCPs must ensure the provision of a leave of absence (LOA)/bed hold by a Subacute Care Facility in accordance with the requirements of 22 CCR section 72520 and California's Medicaid State Plan. MCPs must allow the member to return to the same Subacute Care Facility where they previously resided under the LOA/bed hold policies subject to Medical Necessity in accordance with the Medi-Cal requirements for LOA and bed hold, which are detailed in 22 CCR sections 51535 and 51535.1. MCPs must ensure that members	

Policy Area	Pediatric Subacute Care: FFS	Pediatric Subacute Care: Managed Care	Key Highlights
	51535 and 51535.1. Members have the right to return to the Subacute Care Facility and to the same bed, if available, or at a minimum to the next available room in the facility, regardless of the duration of the hospitalization, pursuant to 42 Code of Federal Regulations (CFR) section 483.15(e). The bed hold is limited to a maximum of seven days per hospitalization. Claims submitted for BH for more than seven days will be denied.	have the right to return to the Subacute Care Facility and to the same bed, if available, or at a minimum to the next available room in the facility, regardless of the duration of the hospitalization, pursuant to 42 Code of Federal Regulations (CFR) section 483.15(e). MCPs must regularly review all denials of bed holds. The bed hold is limited to a maximum of seven days per hospitalization. Claims submitted for BH for more than seven days will be denied.	

Appendix Table D: Adult Subacute Care Carve-In Changes Table

The following table provides a high-level overview of the changes between coverage for Adult Subacute Care services in Fee-For-Service, the current state in 36 counties, and Medi-Cal Managed Care.

Policy Area	Adult Subacute Care: FFS	Adult Subacute Care: Managed Care	Key Highlights
Medical Necessity Criteria	Consistent with definitions in 22 Code of California Regulations (CCR) section 51124.5, Welfare and Institutions Code (W&I) section 14132.25, and the Medi-Cal Manual of Criteria.	Consistent with definitions in 22 Code of California Regulations (CCR) section 51124.5, Welfare and Institutions Code (W&I) section 14132.25, and the Medi-Cal Manual of Criteria.	No change; plans may supplement criteria as they see fit but may not make changes to the existing Medical Necessity Criteria.
Initial Service Authorization	Submit TAR to DHCS and a completed: » Information for Authorization/Reauthorization of Subacute Care Services – Adult Subacute Program (DHCS form 6200A). Information for Authorization/Reauthorization of Subacute Care Services - Adult Subacute Program » DHCS form 6170 Preadmission Screening and Resident Review	Submit TAR to MCP for services. MCPs may require specific authorization/reauthorization forms.	A completed DHCS form 6170 (PASRR) must also be submitted with any TAR requesting subacute level of care.

Policy Area	Adult Subacute Care: FFS	Adult Subacute Care: Managed Care	Key Highlights
	(PASRR) must be completed online and submitted with initial TARs requesting subacute level of care. Refer to the PASRR process found in the Medi-Cal Provider Manual – PASRR. » Medical Doctor (MD) order for admission to subacute facility. Adult Subacute initial authorization requests may be approved for periods of up to six months, as specified in CCR, Title 22, Section 51335.5(c).		
Service Reauthorization	To request authorization for subacute services, providers submit Long Term Care Treatment Authorization Requests (20-1) and state in Section C that the level of care is subacute. Subacute facilities submit the appropriate DHCS 6200 in lieu of MDS 3.0.	Providers will submit forms and documentation required by the MCPs.	

Policy Area	Adult Subacute Care: FFS	Adult Subacute Care: Managed Care	Key Highlights
	Submit TAR to DHCS for services and a completed: » Information for Authorization/Reauthorization of Subacute Care Services – Adult Subacute Program (DHCS form 6200A), or Provide the following clinical documentation: » A detailed summary of acute care hospitalizations for this member during the previous authorization period; » A copy of weekly MD progress notes covering the month prior to TAR submission; » A copy of the notes from the most recent discharge planning conference.		

Policy Area	Adult Subacute Care: FFS	Adult Subacute Care: Managed Care	Key Highlights
	Subacute reauthorization for adult and pediatric may be approved for periods of up to six months, as specified in CCR, Title 22, Sections 51335.5(c) and 51335.6(c). Consistent with APL 23-027, reauthorizations may be approved for one year for members who have been identified or meet the criteria of "prolonged care." Prolonged Care classification specified in the Medi-Cal Manual of Criteria R-15-98E, recognizes that the medical condition of selected members requires a prolonged period of skilled nursing care.		
Subacute Service Codes and Billing Form	Physicians bill for subacute services on the CMS-1500 by specifying the appropriate Place of Service, modifier U2, and billing codes listed in the Subacute Care Programs: Billing	Providers will submit claims to MCPs for payment using National Uniform Billing Committee (NUBC)/Health Insurance Portability and Accountability Act (HIPAA) compliant code sets.	Previously, subacute care providers bill subacute services on the *Payment Request for Long Term Care* 25-1 form. They are transitioning to National Uniform Billing Committee (NUBC) UB-04 effective February 1, 2024.

Policy Area	Adult Subacute Care: FFS	Adult Subacute Care: Managed Care	Key Highlights
	Codes section in the appropriate Part 2 manual.	Facilities will have the option to submit claims digitally.	
TAR Approval	DHCS Clinical Assurance Division (CAD) currently approve TARs for adult subacute level of care in accordance with CCR, Title 22, Sections 51124.5, 51335.5, 51511.5, and the Medi-Cal Manual of Criteria R-15-98E. Authorization shall be based on medical necessity and the lowest cost service in accordance with CCR, Title 22, Sections 51003 and 51303.	The MCPs will review Prior Authorizations after January 1, 2024, and will notify the facilities of approval.	
TAR Denial	CAD notifies the facilities in real time of any denials or modifications. TARs may be denied due to not meeting medical necessity and/or Medi-Cal policy for Adult Subacute LOC.	The MCP will review the TARs and notify the facilities of any denials.	
Credentialing/ Contracting	Responsibility of SCU	Responsibility of SCU.	

Policy Area	Adult Subacute Care: FFS	Adult Subacute Care: Managed Care	Key Highlights
LOAs/Bed Holds	Medi-Cal must ensure the provision of a leave of absence (LOA)/bed hold by a Subacute Care Facility in accordance with the requirements of 22 CCR section 72520 and California's Medicaid State Plan. Medi-Cal must allow the member to return to the same Subacute Care Facility where they previously resided under the LOA/bed hold policies subject to Medical Necessity in accordance with the Medi-Cal requirements for LOA and bed hold, which are detailed in 22 CCR sections 51535 and 51535.1. Members have the right to return to the Subacute Care Facility and to the same bed, if available, or at a minimum to the next available room in the facility, regardless of the duration of the hospitalization, pursuant to 42 Code of Federal Regulations (CFR) section 483.15(e).	MCPs must ensure the provision of a leave of absence (LOA)/bed hold by a Subacute Care Facility in accordance with the requirements of 22 CCR section 72520 and California's Medicaid State Plan. MCPs must allow the member to return to the same Subacute Care Facility where they previously resided under the LOA/bed hold policies subject to Medical Necessity in accordance with the Medi-Cal requirements for LOA and bed hold, which are detailed in 22 CCR sections 51535 and 51535.1. MCPs must ensure that members have the right to return to the Subacute Care Facility and to the same bed, if available, or at a minimum to the next available room in the facility, regardless of the duration of the hospitalization, pursuant to 42 Code of Federal Regulations (CFR) section 483.15(e). MCPs must regularly review all denials of bed holds.	

Policy Area	Adult Subacute Care: FFS	Adult Subacute Care: Managed Care	Key Highlights
	The bed hold is limited to a maximum of seven days per hospitalization. Claims submitted for BH for more than seven days will be denied.	The bed hold is limited to a maximum of seven days per hospitalization. Claims submitted for BH for more than seven days will be denied.	