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Subacute Care Facility Long-Term Care Carve-In Frequently Asked Questions (FAQ)

Introduction

California Advancing and Innovating Medi-Cal, or CalAIM, is an initiative by the Department of Health Care Services (DHCS) 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 is also intended to make Medi-Cal a more consistent and seamless system. One goal of CalAIM is to support service coordination and comprehensive care planning for members residing in Long-Term Care (LTC) facilities. All Medi-Cal members residing in LTC facilities are now enrolled in Medi-Cal managed care plans (MCPs), and those plans cover and coordinate LTC in all counties in the State.

Subacute Care: Background

Subacute Care Facility services include those provided to adult and pediatric populations that are provided by a licensed general acute care hospital with distinct-part skilled nursing beds, or by a freestanding certified nursing facility. In each case, the facility must have the necessary contract with DHCS' Subacute Contracting Unit (SCU).

Please note, additional information about the Subacute Care Facility LTC Carve-In and can be found on the Subacute Care Facility LTC Carve-In Webpage. All Plan Letter (APL) 24-010, Subacute Care Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care, provides requirements to MCPs on the Subacute Care Facility LTC Carve-In.

Subacute Level of Care:

- 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 skilled nursing facility. (CCR Title 22 Section 51124.5(a))
- 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. (CCR Title 22 Section 51124.6 (a))

Subacute Care Carve-In Counties

Prior to January 1, 2024, MCPs had varying levels of coverage for adult and pediatric Subacute Care Facility services. Adult and pediatric subacute services were provided through Medi-Cal MCPs under the institutional LTC services benefit in the following 22 County Operated Health Systems (COHS) counties:

- 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.

Prior to January 1, 2024, only adult subacute services were provided through MCPs under the institutional LTC services benefit in the following 5 (five) non-COHS counties:

- Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara. Pediatric subacute care services will be carved-in effective January 1, 2024.

In the remaining 31 counties, MCPs covered Medically Necessary adult subacute services 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 the members are disenrolled from Medi-Cal managed care and transferred to Medi-Cal Fee-For-Service (FFS) to continue receiving subacute care services:

- 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.

Effective January 1, 2024, DHCS requires all non-dual and dual LTC members (including those with a Share of Cost) receiving adult or pediatric subacute care services to be enrolled in an MCP.

The goal of the Medi-Cal LTC Carve-In is to provide better coordination across institutional and home- and community-based settings as well as to make the LTC delivery system consistent across all counties in California. MCPs can offer complete care coordination, care management, and provide a broader array of services, including CalAIM Enhanced Care Management and Community Supports for Medi-Cal beneficiaries, than the traditional Medi-Cal FFS system. To support this transition, DHCS offered webinars for MCPs and providers, as well as implementation materials posted on the CalAIM LTC Carve-In website.

This document addresses questions regarding the Subacute Care Facility LTC Carve-In and will be updated regularly. Please submit questions about the Subacute Care Facility LTC Carve-In to: LTCtransition@dhcs.ca.gov.

Questions about CalAIM generally should be submitted to CalAIM@dhcs.ca.gov.

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Subacute Care Facility LTC Carve-In Frequently Asked Questions

Network Readiness

1. **Is there a list of Subacute Care Facilities in California?**

   Facilities that have a contract with the DHCS Subacute Contracting Unit (SCU) are available here:

   - Medi-Cal Provider List - Adult
   - Medi-Cal Provider List - Pediatric

2. **Will DHCS provide a list of Subacute Care Facilities that are in the process of applying for a contract with DHCS?**

   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 SCU or is actively in the process of applying for a contract with DHCS' SCU. MCPs can instruct non-DHCS contracted Subacute Care Facilities to apply for a Medi-Cal Subacute Care Facility contract with DHCS' SCU.

   To ensure access to care during the upcoming transition, DHCS SCU will process applications for new contracts as quickly as possible and will post a list of facilities that have applied for a contract on the DHCS SCU website to allow plans to continue to reimburse those facilities during the application process.

   Once an application has been received by DHCS SCU, the provider will be added to the pending application list and will be considered to be "in the process of applying for a contract" until the application has been processed and a contract issued, or the application denied due to the facility's inability to meet requirements for participation in the Medi-Cal Subacute Care Program.

3. **What if a Subacute Care Facility is decertified?**

   DHCS SCU advises MCPs of new contracts, termination of contracts, and Ban of Admissions, and will establish a system of reporting deficiencies found during onsite visits.

   DHCS shares adverse actions with MCPs when received by the California Department of Public Health. Please note, MCPs are required to check the suspended and ineligible providers lists. In accordance with APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations, or any superseding APL, MCPs must comply with requirements relating to CDPH-initiated facility decertifications and suspensions to ensure that impacted members have appropriate transition options and do not experience disruption in access to care.

4. ***(Updated October 2024)*** **Will all MCPs be required to contract with every Subacute Care Facility?**

   MCPs will be required to have and maintain an adequate network consisting of adult and pediatric Subacute Care Facilities. All MCPs must ensure that members in need of adult or pediatric subacute care services are placed in a health care facility that provides the level of care most appropriate to the member's medical needs.

   MCPs must develop sufficient network capacity to enable member placement in Subacute Care Facilities within five (5) Working Days, seven (7) Working Days, or 14 calendar days of a request, depending on the county of residence, as outlined in Welfare and Institutions Code (WIC) section 14197.2

   - **Adult Subacute Care Facilities:** MCPs must attempt to contract with all adult Subacute Care Facilities (provided in both freestanding and hospital-based facilities) outlined in the Medi-Cal list 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.
   - **Pediatric Subacute Care Facilities:** Given the small number of Pediatric Subacute Care Facilities in the state, MCPs must attempt to contract with all pediatric Subacute Care facilities (provided in both freestanding and hospital-based facilities) statewide.

5. **What if there are no Subacute Care Facilities in the MCP's county?**

   If the MCP's county does not have any available Subacute Care Facilities, the MCP must extend contracting efforts to the State region level (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. The MCP must attempt contracting with facilities where their Medi-Cal members reside.

   MCPs may refer to the Subacute Care Network Readiness Requirements document sent by DHCS on June 30, 2023, for a crosswalk of the number of eligible Subacute Care Facilities by county as well as a list of counties by region.

6. **Can you define what a non-DHCS contracted subacute care facility is and what it means to "continue to receive Subacute Care reimbursement"? Is that in reference to the DHCS published subacute rates or to contracted rates for services that may be similar to the services included in the DHCS subacute contract?**

   A facility either holds a Medi-Cal Subacute Care Provider Participation Agreement (PPA (contract)) or it does not. If the facility has a PPA contract, it is a contracted facility, but if the facility does not have a PPA contract, it is a non-DHCS contacted Subacute Care Facility. Any non-contracted facility may apply for participation in the Medi-Cal Subacute Care Program which is required by regulations for Medi-Cal reimbursement for subacute care. The contract provides consistency among providers to ensure consistency of care to Medi-Cal subacute care members.

7. **Is "service area" a defined term? What is the definition?**

   Service Area is a defined term in the MCP contract. Service Area means the county or counties that Contractor is approved to be operated in under the terms of this Contract. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

8. **Can MCPs place members in Subacute Care Facilities with a Letter of Agreement?**

   MCPs should refer to the Subacute Care Network Readiness Requirements sent by DHCS. MCPs must attempt to contract with all adult Subacute Care Facilities within the MCP's service area(s) and all pediatric Subacute Care Facilities in the state, as outlined in the Network Readiness Guide. If an MCP cannot contract with Subacute Care Facilities, the MCP must submit documentation indicating the reasons and provide explanations as to why the MCP was unable to secure a contract with the provider. For members enrolled in facilities out of county, MCPs may also work with those facilities to establish an interim letter of agreement. However, DHCS has informed MCPs that MCPs should seek to replace LOAs with network provider agreements.

Subacute Care Services Benefit

9. **When will DHCS provide plans with a list of newly eligible members?**

   DHCS will provide transition data, including member-level demographic and claims-level data for each MCP's specific transitioning population (including Treatment Authorization Request (TAR) data) in November 2023. Post-implementation (January 2024 and beyond), DHCS will share standard ongoing

data feeds, including data on members new to Medi-Cal or who are transitioning between plans.

Continuity of Care: Members with Existing Treatment Authorization Requests (TARs)

10. How does continuity of care work with existing TARs?

MCPs are responsible for honoring previously approved TARs for subacute care services. The table below summarizes the requirements for adult and pediatric subacute care services for TARs approved by DHCS. Additional information is available in APL 24-010.

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.**
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.**

11. Do the TARs for pediatric supplemental rehabilitation therapy and ventilatory weaning services have a different policy from all other authorized services outside of the per diem rate?

Yes, pediatric supplemental rehabilitation therapy and ventilator weaning services TARs may be separately authorized and reimbursed for eligible pediatric subacute care patients. MCPs are responsible for covering supplemental rehabilitation therapy services and ventilator weaning services for TARs approved by DHCS in a Subacute Care Facility for a period of three months after enrollment in the MCP.

12. What will the TAR approval process look like after the January 1, 2024 subacute care services carve-in?

As outlined in APL 24-010, MCPs are responsible for covering TARs that are approved by DHCS on different timelines depending on the service (see table above). After the initial six- or three-month period, the authorization approval timeframe is subject to prior authorization policies and procedures as established by the MCP in accordance with rules and contract requirements governing utilization management, including prior authorization.

Effective January 1, 2024, MCPs are responsible for covering all open and active (e.g., unexpired) TARs. Subacute Care Facilities can make requests to MCPs for new authorizations beginning January 1, 2024. New authorizations are not required for beneficiaries transitioning from Medi-Cal FFS to a Medi-Cal MCP.

13. How does the 12-month Continuity of Care period align with the TAR authorization/reauthorization time periods?

Per APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, MCPs must provide automatic continuity of care for members transitioning from Fee-For-Service (FFS) to Medi-Cal Managed Care for a period of 12 months. MCPs must also honor existing treatment authorization requests (TARs) that are approved by DHCS for a period of three (3), six (6), or twelve (12) months (depending on whether the TAR is for per diem services, other services, pediatric supplemental rehabilitation therapy and ventilator weaning services, or prolonged care), or for the duration of the TAR approval, whichever is shorter. MCPs may be reviewing TARs prior to the end of the 12-month continuity of care period, but automatic continuity of care still applies to services and facility placement for members receiving subacute care services.

14. Who is responsible for sharing existing TARs for Subacute Care Facility residents with MCPs?

DHCS will provide the data on the transition population to MCPs in November 2023, which will include approved FFS TARs. The file layout is similar to the Seniors and Persons with Disabilities (SPD) TAR Detail File currently sent monthly to MCPs from DHCS.

However, Subacute Care Facilities are encouraged to promptly communicate and provide members' TAR info to the appropriate MCP, once members made their plan selection. While DHCS will be providing MCPs with approved FFS TARs for current Subacute Care Facility residents as part of a data exchange prior to January 1, 2024, further coordination between the Facilities and MCPs may be helpful to ensure a seamless transition. A copy of the TAR form can be sent to the MCP through their LTSS Liaison.

The Preadmission Screening and Resident Review (PASRR)

15. Will DHCS ensure that changes to PASRR requirements and requirements for prior authorization be developed in coordination with all key stakeholders and be communicated to all parties in advance of implementation?

Yes, as PASRR is required **prior** to admitting an individual to a Medicaid-certified SNF, DHCS will ensure that changes to PASRR requirements and requirements for prior authorization be developed in coordination with all key stakeholders and be communicated to all parties in advance of implementation. DHCS works closely with partners to ensure the PASRR process meets federal requirements. Prior to the implementation of the MCP prior authorization requirement, DHCS provided training to the MCPs as well as General Acute Care Hospitals (GACHs) and SNFs.

On August 10, 2023, DHCS released PASRR Information Notice (IN) 23-001 clarifying the prior authorization process for the GACHs and SNFs. Changes to prior authorization requirements regarding PASRR were developed in coordination with all key stakeholders.

Facility Payment

16. **MCPs may not always be the payer for acute inpatient stays (i.e., CCS would likely be the payer for pediatric members in acute inpatient stays). If the Plan is not the payer of services, are specific requirements still applicable to MCPs?**

    If another payer is responsible for a member's stay in a Subacute Care Facility (e.g., California Children's Services or CCS), MCPs are responsible for the coordination of carved-out services and referral to appropriate community resources and other agencies, regardless of whether the MCP is responsible for paying for the service.

17. **What is the reason that state directed payment requirements do not apply to out-of-network providers?**

    Directed payments only apply to network providers, per federal regulations (CFR 438.6 (c)).

18. ***(Updated October 2024)*** **When the FFS per diem rate is updated, when can Subacute Care Facility providers expect to receive payments based on the updated rate?**

    The Medi-Cal FFS per diem rate remains effective until an updated per diem rate is published. When an updated per diem rate is published, MCPs must begin making payments based on this rate for all claims on or after the applicable date of service, within 30 Working Days of being notified by DHCS. The transition to the updated per diem rate may result in revised payments owed to Subacute Care Facilities, retroactively. MCPs are responsible for adjusting claims retroactively and issuing correct payments to Subacute Care Facilities within 45 Working Days after being notified of the published updated rate. MCPs must not require Subacute Care Facilities to resubmit claims as a result of the published updated per diem rate.

    Medi-Cal reimbursement rates for Subacute Care Facilities is available on the DHCS website here: https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx.

Population Health Management

19. Are all members receiving subacute services ineligible and excluded from ECM services, or does this just apply for members residing in Subacute Care Facilities?

Members residing in Subacute Care Facilities are excluded from receiving ECM during their stay on the basis that the care they are receiving in the Subacute Care Facilities is comprehensive and highly specialized.

Long-Term Services and Supports (LTSS) Liaison

20. Can LTSS liaisons be clinical staff?

LTSS liaisons may be but are not required to be clinical staff. They may be operational staff.

21. How can I find my plan's LTSS Liaison?

Per APL 24-010, MCPs must identify their respective LTSS liaisons and must disseminate their LTSS liaisons' contact information to relevant Network Providers, including Subacute Care Facilities that are within Network. Subacute Care Facilities may reach out directly to their MCP for LTSS Liaison contact information.

Adult and Pediatric Subacute Long-Term Care Carve-In: Summary of Inclusive Services

22. Which oxygen supplies are included in the Subacute Care per diem rate?

All oxygen supplies are included in the per diem rate for subacute care facilities. This includes:

- Oxygen and all equipment necessary for administration including positive pressure apparatus.
- Ventilators, including calibration and maintenance.

Subacute facilities have differentiated rates for ventilator dependent individuals, with higher rates for ventilator dependent individuals. Additional information is provided in:

- Manual of Criteria
- 22 CCR 51511.5
- 22 CCR 51511.6
- WIC 14132.25(f)

- Medi-Cal Provider Manual, Subacute Care Programs: Pediatric
- Medi-Cal Provider Manual, Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items

23. Can you provide further clarification on the appropriate payment for pediatric supplemental rehabilitation therapy services and ventilator weaning services?

Supplemental rehabilitation therapy services and ventilator weaning services may be separately authorized and reimbursed for eligible pediatric subacute care patients. Reimbursement for these services is in addition to the per diem rate for pediatric subacute level of care services. An approved TAR is required for these services and is the responsibility of the nursing facility. The payment rate is negotiated between the plan and provider. Please see the Provider Manual on Subacute Care Programs: Pediatric for additional information.

General Questions

24. If a member is placed in a Subacute Care Facility located outside of the MCP's service area, does that member need to be re-enrolled in a local plan?

MCP enrollment is based on a member's residence county. The member may need to change their MCP and make sure their address is updated with their county, depending on length of stay. MCPs may need to secure provider contracts with Subacute Care Facilities outside of their county in order to appropriately meet member needs. For members enrolled in facilities out of county, MCPs may also work with those facilities to establish an interim letter of agreement. However, DHCS has informed MCPs that MCPs should seek to replace LOAs with network provider agreements.

25. Does DHCS have an estimate of the number of subacute patients who will be transferring from FFS to managed care?

As of July 2023, DHCS estimates 1,700 subacute patients will be transitioning from Medi-Cal FFS to Medi-Cal managed care.

26. What happens if a bed in a Subacute Care Facility is not available?

For members in acute care beds who are require subacute level of care and require a subacute bed, MCPs must continue to provide authorization for acute care until the member can be placed in an available bed in a Subacute Care Facility. Beds designated for adult or pediatric subacute care cannot be used for swing beds.

27. What criteria should be used for medical necessity determinations to place members in the subacute level of care?

MCPs must determine Medical Necessity for adult members consistent with the Medi-Cal Manual of Criteria following the definition in 22 Code of California Regulations (CCR) section 51124.5. Medical Necessity for pediatric members may be found in 22 CCR section 51124.6 with supplemental requirements cited in the Welfare and Institutions Code (W&I) section 14132.25. Other medical criteria are meant to supplement the criteria in regulations and other medical criteria should not solely be used in determining subacute level of care.

28. Are Congregate Living Health Facilities (CLHFs), Residential Care Facilities for the Elderly (RCFEs), or Assisted Living Facilities (ARFs) included in the Subacute Care Facility LTC Carve-In?

No, CLHFs, RCFEs, and ARFs are not included in the Subacute Care Facility LTC Carve-In. These facilities are not considered Subacute Care Facilities or long-term care facilities as they are Home and Community-Based Services waiver providers, which are not part of the Subacute Care Facility LTC Carve-In.

***29. (Updated October 2024)* If a member has a Share of Cost (SOC), what are the Subacute Care Facility's recordkeeping responsibilities?**

Subacute Care Facilities are responsible for collecting SOC from members if SOC is indicated in the Medi-Cal eligibility verification system. Subacute Care Facilities are also responsible for reporting the collection of SOC to MCPs on claims submitted for those members. Pursuant to the Johnson v. Rank lawsuit, a member may spend part of their SOC on medically necessary services, supplies, or equipment not covered by Medi-Cal. The Subacute Care Facility will need to subtract those amounts from a member's SOC and collect the remaining SOC amount owned. The expenditures from member's SOC funds must be recorded on the Record of Non-Covered Services (DHS 6114 form). Please refer to the SOC section of the Medi-Cal Provider Manual for more information.

30. What is the grievances and appeals process? If a member has a question about a grievance or complaint, what options do they have for external help?

MCPs are governed by specific Grievances and Appeals (G&A) requirements described in APL 21-011. All members are provided information on the G&A process and steps in their Member Handbook and may contact their MCP at any time to receive information and help.

For questions about Medi-Cal:

- Call the DHCS Medi-Cal Helpline Monday through Friday 8 a.m. to 5 p.m. (excluding holidays) at 1-800-541-5555 (TTY: 1-800-430-7077). The call is free.

For questions about why your Medi-Cal services are changing:

- Call the DHCS Ombudsman Office Monday through Friday 8 a.m. to 5 p.m. (excluding holidays) at 1-888-452-8609 (TTY State Relay: 711). The call is free. You can also email MMCDOmbudsmanOffice@dhcs.ca.gov. The Ombudsman Office helps people with Medi-Cal use their benefits and know their rights and responsibilities.
- Call the Long-Term Care Ombudsman at 1-800-231-4024. The line is available 24 hours a day, 7 days a week. The call is free. The Long-Term Care Ombudsman helps people who reside in a LTC facility with complaints and with knowing their rights and responsibilities.

To learn more about health plan choices and provider (doctor, clinic) choices:

- Call Medi-Cal Health Care Options Monday – Friday, 8 a.m. to 6 p.m. at 1-800-430-4263 (TTY: 1-800-430-7077). The call is free. Or go to www.healthcareoptions.dhcs.ca.gov.