CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: June 10, 2026

ALL PLAN LETTER 26-011

SUPERSEDES ALL PLAN LETTER 24-010

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: SUBACUTE CARE FACILITIES – LONG-TERM CARE BENEFIT UNDER MANAGED CARE

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Subacute Care Facility Long-Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including coverage for Medi-Cal members under managed care.[1]

BACKGROUND:

The term 'Subacute Care Facility' refers to a Skilled Nursing Facility (SNF) that is contracted with the Department of Health Care Services' (DHCS) Subacute Contracting Unit (SCU) to provide Subacute Care services to Medi-Cal members who meet the criteria for Subacute Care. Subacute Care Facility services include those provided to both 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.[2] In each case, the facility must have the necessary contract with DHCS.[3]

Subacute Care patients are medically fragile and require special services, such as inhalation therapy, tracheostomy care, intravenous tube feeding, and complex wound management care. Adult Subacute Care is defined as a level of care needed by a patient

[1] Details on the CalAIM initiative can be found on DHCS' website at the following link: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx.

[2] Subacute level of care refers to very intensive, licensed, skilled nursing care provided in Distinct-Part/Nursing Facilities Level B (DP/NF-B) in acute hospitals, or in Free-Standing Nursing Facilities Level B (FS/NF-B). Beds designated for pediatric Subacute Care cannot be used for swing beds.

[3] 22 California Code of Regulations (CCR) section 51215.6. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.

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 SNF.

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.[4]

Prior to January 1, 2024, MCPs had varying levels of coverage for adult and pediatric Subacute Care Facility services.

- In 22 County Operated Health Systems (COHS) counties, MCPs provided coverage for both adult and pediatric subacute services under the institutional LTC services benefit.[5]
- In five, non-COHS counties, only adult subacute services were covered.[6] In these five counties where pediatric subacute services were not covered under the institutional LTC services benefit, MCPs covered Medically Necessary 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 were disenrolled from Medi-Cal managed care and transferred to Medi-Cal Fee-For-Service (FFS) to continue receiving pediatric Subacute Care services.
- 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 were disenrolled from Medi-Cal managed

[4] More information on Subacute Care is available at: https://www.dhcs.ca.gov/provgovpart/Pages/SubacuteCare.aspx.
[5] The 22 counties where MCPs covered both adult and pediatric subacute services: 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.
[6] The five counties where MCPs covered only adult subacute services: Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara.

care and transferred to Medi-Cal FFS to continue receiving Subacute Care services.[7,8,9]

To further CalAIM's goals to standardize and reduce complexity across the state and reduce county-to-county differences, DHCS implemented benefit standardization across MCPs statewide. Benefit standardization helps ensure consistency in the benefits delivered by Medi-Cal managed care and FFS statewide.[10]

Effective January 1, 2024, DHCS requires most non-dual and dual LTC Members (including those with a Share of Cost (SOC)) receiving institutional LTC services in a Subacute Care Facility or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) to be enrolled in an MCP.[11,12] This APL focuses on Subacute Care services as part of institutional LTC services. APLs specific to SNF and ICF/DD services have been released separately.[13]

POLICY:

I. Benefits Requirements

1. Subacute Care Services Benefits Requirements

---

[7] The 31 counties where MCPs covered pediatric subacute services temporarily: 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.
[8] The 36 counties where MCPs covered both adult and pediatric subacute services: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, and Yuba.
[9] MCP boilerplate Contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. MCPs are advised to refer to their own MCP Contract and any amendments thereto.
[10] See Attachment 1 of APL 21-015, for more detailed information on Mandatory Managed Care Enrollment. APLs and associated attachments are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[11] "Dual" Members are Members enrolled in both Medi-Cal and Medicare. "Non-dual" Members are only enrolled in Medi-Cal.
[12] Welfare and Institutions Code (W&I) 14184.201(b) and (c). State law is searchable at: https://leginfo.legislature.ca.gov/.
[13] See APL 26-010, Skilled Nursing Facilities -- Long Term Care Benefit Under Managed Care and 26-012, Intermediate Care Facilities For Individuals With Developmental Disabilities – Long-Term Care Benefit Under Managed Care.

Effective January 1, 2024, MCPs in all counties must authorize and cover Medically Necessary adult and pediatric Subacute Care services (provided in both freestanding and hospital-based facilities).[14] All MCPs must determine Medical Necessity consistent with definitions in 22 Code of California Regulations (CCR) sections 51124.5 and 51124.6, W&I section 14132.25, and the Medi-Cal Provider Manual.[15] Additionally, Members who are admitted into a Subacute Care Facility remain enrolled in Medi-Cal managed care instead of being disenrolled to Medi-Cal FFS. 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, as outlined in the MCP Contract and as documented by the Member's Provider(s). 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.

2. Other Benefits Requirements for Residents of Subacute Care Facilities

Consistent with guidance in APL 25-013, Medi-Cal Rx Pharmacy Benefits, and Cell Gene Therapy Coverage, the financial responsibility for prescription drugs is determined by the claim type on which they are billed. If certain drugs are dispensed by a pharmacy and billed on a pharmacy claim, they are carved out and paid by Medi-Cal Rx. If the drugs are provided by the Subacute Care Facility and billed on a medical or institutional claim, the MCP is responsible.

For MCPs covering adult and pediatric Subacute Care services effective January 1, 2024, financial responsibility for prescription drugs is determined by claim type, as discussed above, since the Medi-Cal FFS Subacute Care Facility per diem rate does not include legend drugs (prescription drugs).[16] MCPs may choose to cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered by Medi-Cal.

---

[14] Accommodation codes for LTC facilities are listed at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/hipaa-ltc-home. Medi-Cal Provider Manuals are located at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual.

[15] See the Long Term Care Medi-Cal Provider Manual, at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=long-term-care.

[16] 22 CCR sections 51510 and 51511.

MCPs must comply with Population Health Management (PHM) requirements as set forth in Part XI below, which include the coordination of Medically Necessary drugs or medications on behalf of the Member.[17,18]

MCPs must cover all Medically Necessary services covered under the MCP Contract for Members residing in or obtaining care in a Subacute Care Facility, including facility services, professional services, and ancillary services. MCPs must also provide the appropriate level of Care Coordination, including for carved-out Medi-Cal services, as outlined in this APL and in adherence to contractual requirements and the DHCS PHM Policy Guide.[19]

II. Network Requirements

MCPs must offer a contract to all Subacute Care Facilities within the MCP's service area(s) that have a Subacute Care Contract with DHCS' SCU or are actively in the process of applying for a Medi-Cal Subacute Care Contract and are enrolled in Medi-Cal. MCPs may instruct non-DHCS contracted Subacute Care Facilities that they must contract with DHCS or be actively in the process of applying for a Medi-Cal Subacute Care Facility contract in order to receive payment. A list of approved and active Subacute Care Facilities can be found on the DHCS SCU website.[20]

MCPs must have sufficient Network capacity to enable Member placement in Subacute Care Facilities within 5 Working Days, 7 Working Days, or 14 calendar days of a request, depending on the county of residence, as outlined in W&I section 14197(d). MCPs must have sufficient Network capacity to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the Member's condition consistent with good professional practice.[21]

If MCPs cannot enable Member placement during these timeframes or demonstrate sufficient Network capacity, MCPs must allow placement at out-of-Network facilities.

---

[17] See Part XI below, titled Population Health Management Requirements for further information.
[18] More information on coverage of Medi-Cal pharmacy services through Medi-Cal Rx is available at: https://medi-calrx.dhcs.ca.gov/home/ and https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=ratefacilmisc.pdf.
[19] The PHM Policy Guide is available at: https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf.
[20] The list of adult and pediatric Subacute Care Facilities contracted with DHCS can be found under the Additional Resources section of the DHCS SCU website at: https://www.dhcs.ca.gov/provgovpart/Pages/SubacuteCare.aspx.
[21] Health and Safety Code (H&S) section 1367.03(a)(1).

This includes ensuring access within timely access standards, regardless of provider or transportation costs. Out-of-Network referrals must be authorized for all Medically Necessary services, consistent with the MCP Contract and applicable APLs. A Letter of Agreement does not constitute a Network Provider Agreement.[22]

MCPs must make every effort to assess the various Provider types currently serving Members residing in Subacute Care Facilities and maintain an adequate Network with them to ensure care is not disrupted and Members receive timely care. For example, when Medically Necessary, it is the MCP's responsibility to cover a Member's transportation to dialysis, as well as dialysis services provided outside the Subacute Care Facility.

In accordance with APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations, MCPs must comply with requirements relating to California Department of Public Health (CDPH)-initiated facility de-certifications and suspensions to ensure that impacted Members are transitioned appropriately and do not experience disruption in access to care.

MCPs must also ensure Members have appropriate transition options and continue to have access to care when there is a Medi-Cal Subacute Care Facility contract termination. MCPs must create policies to ensure no new admissions of Members occur in facilities that have bans of admissions from DHCS' SCU.

III. Leave of Absence or Bed Hold Requirements

MCPs must provide continuity of care for Members who are transferred from a Subacute Care Facility to a general acute care hospital and then require a return to a Subacute Care Facility level of care due to Medical Necessity. Requirements regarding leave of absence (LOA), bed hold, and continuity of care policies apply.[23]

MCPs must ensure that the provision of LOAs and bed holds that a Subacute Care Facility provides comply with the requirements of 22 CCR section 72520 or California's Medicaid State Plan.[24] MCPs must allow the Member to return to the same Subacute Care Facility where the Member previously resided 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 a Subacute Care Facility notifies the Member or the

[22] See APL 26-007, Medi-Cal Managed Care Plan Guidance on Network Provider Agreements.
[23] See H&S sections 1367.09 ("Return to skilled nursing") and 1373.96 ("completion of covered services").
[24] The California Medicaid State Plan can be accessed at the following link: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx.

Member's Authorized Representative in writing of the right to exercise the bed hold provision.[25] MCPs cannot require a separate authorization for a bed hold once authorization for subacute services is granted, provided that the Member returns to the same subacute facility at the same level of care following an acute hospital stay of seven days or less.[26] In a similar protection for Members who have been transferred from a Subacute Care Facility to a general acute care hospital, 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).[27]

MCPs must regularly review all denials of bed holds. Additionally, MCPs must provide transition assistance and Care Coordination to a new Subacute Care Facility when a Subacute Care Facility claims an exception under the bed hold regulations or fails to comply with the regulations. If a Member who has been hospitalized in an acute care hospital asserts their right to readmission under the law, but the Subacute Care Facility refuses to readmit them, the Member has the right to appeal the facility's refusal under H&S section 1599.1(h)(1). If the Member files such an appeal, the Member must remain in the hospital and the hospital may be paid in accordance with the agreed-upon contracted rates as outlined in the Network Agreement, or other contractual arrangement such as a letter of agreement, for the relevant length of stay pending final determination of the appeal, unless the Member agrees to placement in another Subacute Care Facility.[28]

MCPs must ensure that the Subacute Care Facility and its staff have appropriate training on LOA and bed hold requirements, including knowledge of the required clinical documentation to exercise these rights.

IV. Continuity of Care Requirements

Members Who Resided in a Subacute Care Facility January 1, 2024, through June 30, 2024, and Transitioned from Medi-Cal FFS to Medi-Cal Managed Care

Effective January 1, 2024, through June 30, 2024, for Members that resided in a Subacute Care Facility and transitioned from Medi-Cal FFS to Medi-Cal managed care, MCPs were required to automatically provide 12 months of continuity of care for the

[25] See 22 CCR section 72520(b) for more information.
[26] See 22 CCR sections 51535.1 and 51535.1(c)(6).
[27] The CFR is searchable at: https://www.ecfr.gov/.
[28] H&S section 1599.1(h)(3).

Subacute Care Facility placement. Automatic continuity of care meant that if the Member resided in a Subacute Care Facility, they did not have to request continuity of care to continue to reside in that facility. While Members were required to meet Medical Necessity criteria for adult or pediatric Subacute Care services, continuity of care was to be automatically applied.

MCPs were required to allow these Members to stay in the same Subacute Care Facility under continuity of care if all of the following applied:

- The facility was contracted or actively in the process of being contracted by DHCS' SCU;
- The facility was licensed by CDPH;
- The facility was enrolled as a Medi-Cal Provider;
- The Subacute Care Facility and MCP agreed to payment rates that met state statutory requirements;[29] and
- The facility met the MCP's applicable professional standards and had no disqualifying Quality of Care issues.

MCPs were required to determine if Members were eligible for automatic continuity of care before the transition from Medi-Cal FFS to Medi-Cal managed care by identifying the Member's Subacute Care Facility residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or Provider. A pre-existing relationship meant that the Member had resided in the Subacute Care Facility at some point during the 12 months prior to the date of their enrollment in the MCP.

Following their initial 12-month automatic continuity of care period, Members were permitted to request an additional 12 months of continuity of care pursuant to the process established by APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, on or after January 1, 2023.

<u>Members Residing in a Subacute Care Facility and Transitioning from Medi-Cal FFS to Medi-Cal Managed Care on or after July 1, 2024</u>

A Member residing in a Subacute Care Facility who newly enrolls in an MCP on or after July 1, 2024, does not receive automatic continuity of care. The Member must instead request continuity of care, following the process established by APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from

[29] W&I section 14184.201(b).

Medi-Cal Fee-For-Service, on or After January 1, 2023. Pursuant to APL 23-022, MCPs must notify the Member or their Authorized Representative of the Member's right to request continuity of care and furnish a copy of the notification to the Subacute Care Facility in which the Member resides.

If a Member is unable to access continuity of care as requested, the MCP must provide the Member, or their Authorized Representative, with a written Notice of Action (NOA) of an Adverse Benefit Determination in accordance with APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates. The MCP must also provide the NOA to the Subacute Care Facility in which the Member resides.

MCPs must also comply with continuity of care and discharge requirements in H&S section 1373.96 and 28 CCR section 1300.67.1, and ensure compliance of their Subacute Care Facility Providers with all applicable federal and state authorities relating to discharges and patient rights, including 42 CFR section 483.15(c) and 22 CCR section 72527(a)(6). MCPs must provide continuity of care pursuant to H&S section 1373.96 for Members receiving LTC services who transition from one MCP to another.[30] MCPs must also retroactively approve a continuity of care request and reimburse Providers for services that were already provided if the request meets all continuity of care requirements outlined in APL 23-022.

V. Treatment Authorization and Prior Authorization Requests

1. Treatment Authorization and Prior Authorization Requests for Adult and Pediatric Subacute Care Services Under Per Diem Rate

   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 Treatment Authorization Requests (TARs) approved by DHCS for Subacute Care services provided under the Subacute Care Facility per diem rate for a period of six months after enrollment in the MCP, or for the duration of the TAR, whichever is shorter. The MCP must honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, Authorized Representative, or Provider in accordance with the requirements in APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023.

[30] 42 CFR section 438.62(b)

MCPs may approve subsequent reauthorizations for up to one year. MCPs must authorize adult and pediatric Subacute Care services based on Members' meeting Medical Necessity criteria.

A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and the Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition TAR approval.

Approval for pediatric Subacute Care services cease once the Member turns 21 years of age. Authorization requests for pediatric Members should not exceed the Member's 21st birthday. Discharge planning to an adult Subacute Care Facility must be completed at least two months prior to the Member turning 21 years of age.[31]

2. Treatment Authorization Requests for Other Services

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 all other DHCS-approved TARs for services approved by DHCS (except for supplemental rehabilitation therapy services and ventilator weaning services for Members in pediatric Subacute Care Facilities, as discussed below) provided in a Subacute Care Facility exclusive of the Subacute Care Facility per diem rate for a period of six months after enrollment in the MCP, or for the duration of the TAR, whichever is shorter. The MCP must honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, Authorized Representative, or Provider in accordance with the requirements in APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023.

[31] 22 CCR section 51124.6(a)

MCPs may approve subsequent reauthorizations for up to one year. MCPs must authorize adult and pediatric Subacute Care services based on Members' meeting Medical Necessity criteria.[32,33,34]

A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and the Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition TAR approval.

Approval for pediatric Subacute Care services ceases once the Member turns 21 years of age. Authorization requests for pediatric Members should not exceed the Member's 21st birthday. Discharge planning to an adult Subacute Care Facility must be completed at least two months prior to the Member turning 21 years of age.[35]

3. Treatment Authorization and Prior Authorization Requests for Pediatric Supplemental Rehabilitation Therapy and Ventilator Weaning Services

   Supplemental rehabilitation therapy services and ventilator weaning services may be separately authorized and reimbursed for eligible pediatric subacute 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.

   Effective January 1, 2024, for pediatric Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, 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. The MCP must honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, Authorized Representative, or Provider in accordance with the requirements in APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who

---

[32] The Medi-Cal Provider Manual, Part 2 Long Term Care, Subacute Care Programs: Level of Care for Adults and Children is available at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=subacutlev.pdf.
[33] 22 CCR section 51335.5
[34] 22 CCR section 51335.6
[35] 22 CCR section 51124.6(a)

Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023.

MCPs may approve subsequent reauthorizations for up to three months. A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and the Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition TAR approval.

Approval for pediatric Subacute Care services ceases once the Member turns 21 years of age. Authorization requests for pediatric Members should not exceed the Member's 21st birthday. Discharge planning to an adult Subacute Care Facility must be completed at least two months prior to the Member turning 21 years of age.[36]

4. Additional Treatment Authorization and Prior Authorization Request Requirements

   Initial treatment authorizations or Prior Authorizations are required for each new adult and pediatric admission to a Subacute Care Facility. Initial authorizations and subsequent reauthorizations may be approved for up to one year.[37,38] MCPs must expedite Prior Authorization requests for Members who transition from an acute care hospital to a Subacute Care Facility, and make an authorization decision in a timeframe appropriate for the nature of the Member's condition, but no longer than 72 hours after the MCP receives relevant information needed to make an authorization decision.[39,40] MCPs must not require reauthorizations for Subacute Care Services for Members that transfer from a Subacute Care Facility to an acute care hospital, are place on a bed hold, and then return to the same Subacute Care Facility at the same level of care with seven days or less.[41]

---

[36] 22 CCR section 51124.6(a)
[37] The Medi-Cal Provider Manual is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7C1CB9B6-A621-4960-9DFE-24E5A0AC08D9/subacutlev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.
[38] This updated APL controls over any other regulation or guidance as it relates to MCP Subacute Care authorization timeframes.
[39] The 72-hour resolution timeframe includes weekends.
[40] MCPs remain subject to Utilization Management requirements under H&S section 1367.01, and the MCP Contract at Exhibit A, Attachment III, Subsection 2.3.2.
[41] See 22 CCR sections 51535.1 and 51535.1(c)(6).

Prior Authorization requests for Subacute Care Facility services must not require the Minimum Data Set (MDS) for authorization nor request additional information beyond what is required by DHCS in the 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). MCPs should include revenue codes on all Prior Authorizations, and ensure Prior Authorizations state the MCP, Subcontractor, or Downstream Subcontractor responsible for payment of any related claims. MCPs must ensure that payment is made in accordance with the service provided based on revenue codes in contractual agreements.

If the MCP delegates Prior Authorization, authorization must indicate financial responsibility to clearly indicate where Providers should submit claims for authorized services.

VI. The Preadmission Screening and Resident Review

To prevent an individual from being erroneously admitted or retained in a Subacute Care Facility, federal law requires proper screening and evaluation before such placement. These Preadmission Screening and Resident Review (PASRR) requirements are applicable for all Medicaid-certified Subacute Care facilities for all admissions (regardless of payer source). The PASRR process is required to ensure that individuals who may be admitted into a Subacute Care Facility for a long-term stay be preliminarily assessed for serious mental illness or intellectual disability /developmental disability or related conditions.

MCPs must ensure that facilities discharging patients to Medicaid certified Subacute Care Facilities obtain a completed PASRR before discharging patients and transfer the PASRR documents to the admitting Subacute Care Facility. If a prospective Subacute Care Facility patient is currently in a community setting, the admitting Subacute Care Facility must obtain completed PASRR documents prior to admission. 42 CFR Section 483.122 bans payments for Subacute Care Facility services when the PASRR process has not been completed. If an MCP wants to confirm that the Subacute Care Facility has completed the PASRR process, the Subacute Care Facility should be able to provide the Level I Screening and a completed PASRR document with their authorization request, or the MCP may check the DHCS PASRR Online System.[42] The PASRR process is not

[42] Additional information regarding the PASRR process can be found at: https://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx

intended to hinder placement. Hospitals/SNFs are encouraged to proceed with identifying placement while Prior Authorization approval is pending.

VII. Facility Payment

In accordance with W&I section 14184.201(c)(2), for Contract periods from January 1, 2024, to December 31, 2025, inclusive, each MCP must reimburse a Network Provider furnishing adult or pediatric Subacute Care services to a Member and each Network Provider of adult or pediatric Subacute Care services must accept, the payment amount the Network Provider would be paid for those services in the Medi-Cal FFS delivery system, as defined by DHCS in the California's Medicaid State Plan and in guidance issued as authorized by W&I section 14184.102(d). As authorized by W&I section 14184.201(b)(2), DHCS has elected to extend this requirement through December 31, 2026. DHCS may elect to extend this requirement for future Rating Periods through subsequent APLs. This reimbursement requirement is subject to approval by the Centers for Medicare and Medicaid Services (CMS) as a state-directed payment arrangement in accordance with 42 CFR section 438.6(c), and is subject to future budgetary authorization and appropriation by the California Legislature.

In counties where extended coverage of adult or pediatric Subacute Care services transitioned from Medi-Cal FFS to Medi-Cal managed care on January 1, 2024,[43,44] MCPs must reimburse Network Providers of adult or pediatric Subacute Care services for those services at exactly the applicable Medi-Cal FFS per diem rates for dates of service from January 1, 2024, through December 31, 2026, in accordance with W&I section 14184.201(c)(2), this APL, and the terms of the CMS-approved state-directed payment preprint.[45]

In counties where extended adult or pediatric Subacute Care services were already included as a Covered Service under the MCP Contract prior to January 1, 2024, MCPs must reimburse Network Providers of adult or pediatric Subacute Care services for those services at no less than the applicable Medi-Cal FFS per diem rates for dates of service from January 1, 2024, through December 31, 2026, in accordance with W&I section

[43] For adult Subacute Care services, this requirement applies to MCPs in the 31 counties listed in footnote 7.
[44] For pediatric Subacute Care services, this requirement applies to MCPs in the counties listed in footnote 8.
[45] FFS per diem Rates on File for LTC facilities are available at https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx

14184.201(c)(2), this APL, and the terms of the CMS-approved state-directed payment preprint as applicable.[46]

The reimbursement requirement applies to adult or pediatric Subacute Care services starting on the first day of a Member's stay (please see Attachment A). Medi-Cal FFS per diem rates for adult Subacute Care services are all-inclusive rates differentiated between ventilator and non-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.

This reimbursement requirement applies only to payments made directly for adult or pediatric Subacute Care services rendered, and does not apply to other types of payments, including but not limited to, Provider incentive and pay-for-performance payments.

VIII. Payments for Medi-Cal Covered Services for Members Residing in a Subacute Care Facility

The state-directed payment requirements do not apply to any other services provided to a Member receiving adult or pediatric Subacute Care services such as, but not limited to, subacute 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 the terms negotiated between the MCP and the Provider. For a list of adult and pediatric Subacute Care services that are included and excluded in the per diem rate, please refer to Attachment A.

MCPs must coordinate benefits with Other Health Coverage (OHC) programs or entitlements in accordance with APL 22-027, Cost Avoidance and Post-Payment Recovery for Other Health Coverage.

For adult or pediatric Subacute Care services provided to Members who are dually eligible for Medi-Cal and Medicare, MCPs must pay the full deductible and coinsurance in accordance with APL 13-003, Coordination of Benefits: Medicare and Medi-Cal. The

[46] For adult Subacute Care services, this requirement applies to MCPs in the following 27 counties: Del Norte, Humboldt, Lake, Lassen, Los Angeles, Marin, Merced, Mendocino, Modoc, Monterey, Napa, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. For pediatric Subacute Care services, this requirement applies to MCPs in the following 22 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.

existence of OHC must not impede access to adult or pediatric Subacute Care services. Providers contracted through OHC need not contract with the MCP in order to see the Member and bill the MCP for OHC-related costs.

IX. Payment Processes Including Timely Payment of Claims

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

MCPs, including all Subcontractors and Downstream Subcontractors, must make timely payments in accordance with the prompt payment standards within the MCP Contract and APL 23-020, Requirements for Timely Payment of Claims. DHCS expects MCPs to pay Clean Claims within 30 calendar days of receipt. MCPs are highly encouraged to remit claims and invoices in the same frequency (e.g., weekly, monthly) in which they are received.

Medi-Cal FFS per diem rates may be updated by DHCS for specified dates of service. The Medi-Cal FFS per diem rate published for the latest dates of service remains effective for subsequent dates of services, until such time that an updated per diem rate is published for subsequent dates of service. MCPs must implement payment of the updated per diem rate on a prospective basis for all claims with applicable dates of service, received on or after 30 Working Days of being notified by DHCS that the updated rates are published. If additional amounts are owed retroactively in accordance with this APL and the terms of this state directed payment to a Network Provider of adult or pediatric Subacute Care services on any claims for applicable dates of service that were processed prior to the MCP implementing the updated per diem rates on a prospective basis, then MCPs must pay any necessary retroactive adjustments within 45 Working Days after being notified by DHCS that the updated rates are published.[47] MCPs must retroactively reprocess claims for specified dates of service to effectuate the updated rate automatically, without requiring manual reprocessing or resubmission by the Network Provider. MCPs are expected to comply with these reimbursement requirements immediately upon issuance of this APL. If, because of a retroactive decrease in the published rate, amounts previously paid by an MCP are owed

[47] Rates will be available on the DHCS LTC Reimbursement webpage at: https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx.

retroactively by the Provider to the MCP in accordance with this APL and the terms of this state directed payment, then the MCP must recoup such amounts in a timely manner, but no later than within 365 calendar days after being notified by DHCS that the updated rates are published. This retroactive adjustment shall not be considered to result in an overpayment for the purposes of 28 CCR section 1300.71(b)(5).

For the purposes of timely payment requirements specified in APL 23-020, Requirements for Timely Payment of Claims, effective for dates of service on or after January 1, 2026, any additional amount owed retroactively in accordance with this APL is considered a portion of a claim as described in H&S section 1371. An MCP owes the Provider interest on any unpaid additional amount owed at the rate of 15 percent per annum beginning on the first calendar day after the latter of:

1. 45 Working Days of being notified that the updated rates applicable to the claim have been published by DHCS, as described above.
2. 30 calendar days of receipt of claims.[48]

The MCP must automatically include all accrued interest in any late payment. This paragraph does not relieve the MCP of any other interest that may be owed on any other portion of a claim under APL 23-020, Requirements for Timely Payment of Claims, or applicable state and federal law.

For purposes of ensuring payment to Subacute Care Facilities that may undergo a change of ownership or change of the licensed operator, pursuant to W&I section 14126.023(c)(4), Supplement 4 of Attachment 4.19-D of the California Medicaid State Plan, and LTC Rates Policy Letter 23-002,[49] facilities that have a change of ownership or change of the licensed operator must continue to receive the facility per diem reimbursement rate in effect with the previous owner. MCPs should identify the previous owner or operator's rate by referencing the Department of Health Care Access & Information Facility Identification Number (HCAI ID) on the published Medi-Cal LTC FFS per diem rates on file. The HCAI ID remains constant for the facility during a change in ownership or licensed operator. MCPs must implement payment of the correct facility

---

[48] Assembly Bill 3275 (Stats. 2024, Ch. 763) amended the requirement in H&S section 1371 effective January 1, 2026. Please see Department of Managed Health Care APL 25-007: Assembly Bill 3275 Guidance (Claim Reimbursement) available at https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL25-007-AssemblyBill3275Guidance(Claim%20Reimbursement)(4_1_2025).pdf?ver=i37HpYGfgP6BHL3ghvJ4QQ%3d%3d for further guidance.

[49] The LTC Rates Policy Letter 23-002 is available at: https://www.dhcs.ca.gov/services/medi-cal/Documents/AB1629/AB1629_WebUpdates/LTCRPL-23-002-FSSNF-CHOW-Rates-2023.pdf.

per diem reimbursement rate to the new owner or licensed operator upon the new owner or licensed operator becoming a Network Provider. DHCS sends rate letters to notify facilities once a rate change has been implemented in the DHCS FFS Fiscal Intermediary's billing and payment system for FFS claims billed directly to DHCS. MCPs must not require the new owner or licensed operator to present a facility rate letter issued by DHCS.

MCPs must ensure that Network Providers of adult or pediatric Subacute Care services receive reimbursement in accordance with the above requirements for all qualifying services regardless of any Subcontractor arrangements.

Payments processes including timely payment of claims requirements for Network Providers also apply for out-of-Network Providers when those dates of service are under continuity of care.

MCP Contracts require MCPs to have a formal Provider dispute resolution process. DHCS specifies that MCPs must have a formal procedure to accept, acknowledge, and resolve Provider disputes related to the reimbursement of Subacute Care Facility services, including compliance with any applicable Medi-Cal FFS per diem rate requirements and the processing of prospective and retroactive rate adjustments. MCPs must accept Provider disputes related to retroactive rate adjustments as timely, without regard to the underlying date of service or claim submission, if the Provider alleges that the MCP has failed to effectuate the retroactive rate adjustment or pay any required interest within the timeframe required by this APL. MCPs must track the number of Providers who initiate the Provider dispute resolution process, the disposition of those disputes, and the time frames for resolution and/or final disposition. DHCS may request information regarding the Provider disputes and how they were resolved. MCPs must maintain records to respond to DHCS's request for information regarding Provider disputes.

X. Share of Cost

MCPs must process claims submitted by Subacute Care Facilities consistent with the Medi-Cal guidelines for SOC outlined in the Medi-Cal LTC Provider Manual.[50] When a Member has an SOC, the Subacute Care Facility will subtract the SOC payment collected or obligated payment from the claim amount and submit the claim to the MCP to pay the balance.

[50] Provider Manuals are available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual.

Also, the Johnson v. Rank settlement[51] allows Medi-Cal members, not their Providers, to elect to use the SOC funds to pay for necessary, non-covered, medical or remedial care services, supplies, equipment, and drugs (medical services) that are prescribed by a physician and part of the plan of care authorized by the Medi-Cal member's attending physician. The physician's prescriptions for SOC expenditures must be maintained in the Medi-Cal member's medical record. If a Medi-Cal member spends part of their SOC on necessary, non-covered, medical or remedial care services or items, the Subacute Care Facility will subtract those amounts from a Medi-Cal member's SOC and collect the remaining SOC amount owned. The Subacute Care Facility will adjust the amount on the claim and submit the claim to the MCP to pay the balance. Further DHCS guidance regarding Johnson v. Rank requirements are available in the Medi-Cal LTC Provider Manual.

Subacute Care Facilities that collect SOC payments or obligated payments are responsible for certifying SOC in the Medi-Cal eligibility verification system to show the Medi-Cal member has paid the SOC or has an obligated payment for the monthly SOC amount owed. Instructions for Providers to perform SOC clearance transactions in the Medi-Cal eligibility verification system are provided in Part 1 of the Medi-Cal Provider Manual.

XI. Population Health Management Requirements

In addition to benefit standardization, effective January 1, 2023, MCPs were required to implement a PHM Program that ensures all Members, including those using adult or pediatric 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), Transitional Care Services (TCS), care management programs, and Community Supports, as appropriate.

BPHM applies an approach to care that ensures needed programs and services, including primary care, are made available to each Member at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs, all MCP Members receive BPHM, regardless of their level of need. BPHM replaces DHCS' previous "Basic Case Management" requirements.

[51] A summary of the settlement is available at: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c89-54.pdf.

As part of their PHM Program, MCPs must provide strengthened TCS.[52] Effective January 1, 2023, MCPs are required to implement timely Prior Authorizations for **all Members**, and know when **all Members** are admitted, discharged, or transferred from facilities, including Subacute Care Facilities. MCPs must also ensure that all TCS are completed for **all high-risk Members**[53] including assigning a single point of contact, referred to as a care manager, to 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 Subacute Care Facility are timely and do not delay or interrupt any Medically Necessary services or care, and that required transitional care activities are completed. Effective January 1, 2024, MCPs are required to ensure all TCS are provided to all transitioning Members.

Care management beyond transitions consists of two programs: (1) Complex Care Management (CCM); and (2) Enhanced Care Management (ECM). If a Member is enrolled in either CCM or ECM, TCS must be provided by the Member's assigned care manager. MCPs must also continue to provide all elements of BPHM to Members enrolled in care management programs.

CCM is a service for Medi-Cal managed care Members who need extra support to avoid adverse outcomes, but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic Care Coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner.

ECM is a whole-person, interdisciplinary approach to comprehensive care management for Medi-Cal managed care Members who meet the Populations of Focus criteria. It is intended to address the clinical and non-clinical needs of high-cost, high-need Members through systematic coordination of services and it is community-based, interdisciplinary, high-touch, and person-centered. 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.

Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address Social Drivers of

---

[52] More information on TCS for Members with Long Term Services and Supports (LTSS) needs is available at: https://www.dhcs.ca.gov/CalAIM/Documents/TCS-TA-Resource-for-LTSS-Transitions.pdf.

[53] Members receiving LTSS, including adult and pediatric Subacute Care services, are one of the groups considered to be "high risk".

Health. MCPs are strongly encouraged to offer Community Supports services to Members who meet applicable criteria. All MCPs are encouraged to offer as many as possible of the Community Supports approved by DHCS.

For more information about PHM, please refer to the DHCS PHM website[54]; the PHM Policy Guide[55]; APL 22-024, Population Health Management Program Guide; and the MCP Contract. For more information about ECM or Community Supports, please refer to the DHCS ECM and Community Supports website[56]; APL 23-032, Enhanced Care Management Requirements; APL 21-017, Community Supports Requirements; the Finalized ECM and Community Supports MCP Contract Template[57]; the ECM Policy Guide[58]; and the Community Supports Policy Guides.[59]

XII. Long-Term Services and Supports Liaison

MCPs, including all Subcontractors and Downstream Subcontractors, must identify an individual or set of individuals as part of their Provider Relations or related functions to serve as the liaison for LTSS Providers. LTSS includes LTC services provided by Subacute Care Facilities. Liaisons must receive training on the full spectrum of rules and regulations pertaining to Medi-Cal covered LTC, including resident rights under State and federal law, payment and coverage policies, prompt claims payment requirements, provider dispute resolutions policies and procedures (P&Ps), and care management, Care Coordination, and TCS policies. LTSS liaisons must assist Providers in addressing claims and payment inquiries and assist with care transitions among the LTSS Provider community to best support Members' needs. LTSS liaisons are not required to be clinical licensed professionals; they may be fulfilled with non-licensed staff. MCPs must identify

---

[54] The DHCS PHM webpage is located at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx

[55] The PHM Policy Guide is available at: https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf.

[56] The ECM and Community Supports webpage is located at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx.

[57] The finalized ECM and Community Supports MCP Contract Template is available at https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf.

[58] The ECM Policy Guide is available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf.

[59] Volume 1 of the Community Supports Policy Guide is available at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf. Volume 2 of the Community Supports Policy Guide is available at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf.

their respective LTSS liaisons and must disseminate their LTSS liaisons' contact information to relevant Network Providers, including Subacute Care Facilities that are within Network. Per the MCP Contract, MCPs must notify Providers of any changes to the LTSS liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within five days of the change.

Beginning in calendar year 2026, each MCP must hold an "office hours" webinar at least once per calendar quarter for all eligible Network Providers furnishing LTC services to present updates related to P&Ps pertaining to LTC services and answer frequently asked questions, including but not limited to, payment and coverage policies, prompt claims payment requirements, Provider resolutions P&Ps, and care management, coordination and transition policies. The webinar must allow these Network Providers to participate virtually via telephone and optionally via an online teleconference service. The webinar must provide the capability and opportunity for Network Providers to ask live questions. At least 30 days before the webinar, each MCP must publish, on a public internet website, the date and time of the webinar and instructions to join and notify all applicable Network Providers. DHCS may provide additional guidance to MCPs regarding the required timing, content, and duration of webinars.

XIII. MCP Quality Monitoring

MCPs are responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. MCPs must have a system in place to collect quality assurance and improvement findings from CDPH and DHCS' SCU to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings.

The MCP's comprehensive QAPI program must incorporate the following:

- Contracted Subacute Care Facility's QAPI programs, which must include five key elements identified by CMS;[60]
- Mechanisms to assess the quality and appropriateness of care furnished to Members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan;
- Efforts supporting Member community integration; and

[60] QAPI five key elements are available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/qapifiveelements.pdf.

- DHCS and CDPH efforts to prevent, detect, and remediate identified critical incidents.

XIV. Monitoring and Reporting

MCPs are required to report on LTC measures within the Managed Care Accountability Set (MCAS) of performance measures.[61] MCPs are required to calculate the rates for each MCAS LTC measure for each Subacute Care Facility within their Network for each reporting unit. MCPs will be held to quality and enforcement standards in APL 24-004, Quality Improvement and Health Equity Transformation Requirements and APL 25-007, Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions, respectively.

MCPs are also required to annually submit QAPI program reports with outcome and trending data as specified by DHCS.

XV. Policies and Procedures

Within 90 days of the release of this APL, MCPs must update and submit their contractually required P&Ps to include all requirements in this APL to the Managed Care Operations Division (MCOD)-MCP Submission Portal.[62] In addition, MCPs must submit any P&Ps required in any DHCS deliverables lists for LTC to their MCOD Contract Manager.

MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. DHCS may impose enforcement actions, including corrective action plans, as well as administrative and/or monetary sanctions for non-compliance. MCPs must review their Subcontractor, Downstream Subcontractor, and Network Provider Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding enforcement actions, see APL 25-007, Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions. Any failure to meet the requirements of this APL may result in enforcement actions.

---

[61] See the Measurement Year 2023/Reporting Year 2024 MCAS.
[62] The MCOD-MCP Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dennis Hsieh

Dennis Hsieh, Chief

Managed Care Quality and Monitoring Division

Adult and Pediatric Subacute LTC Carve-In:

Summary of Inclusive Services

Attachment A

Below is summary of services included in the per diem rate for adult and pediatric Subacute Services, per state guidelines. These tables are not meant to be exhaustive. Please see sources for additional information.

Summary of Services Included/Excluded in Adult Subacute Carve-In Per Diem Rate

Included Services in Adult Subacute Per Diem Rate
Summary: All services, equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria[63]
Oxygen and all equipment necessary for administration including: • Positive pressure apparatus (e.g., biphasic positive airway pressure) • Oxygen conserving devices (e.g., Oxymizer) • Nebulizers (e.g., Pulmoaide)
Ventilators, including humidifiers, in-line condensers, and in-line temperature measuring devices, calibration and maintenance
Feeding pumps and equipment necessary for tube feedings (nasogastric or gastrotomy), including formula
Speech therapy and language and audiology services[64]
Occupational therapy services[65]
Physical therapy[66]
Equipment and supplies necessary for the care of a tracheostomy, including tracheostomy speaking valves
Respiratory and inhalation therapy services administered by other than a physician

[63] See the Medi-Cal Provider Manual, located at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=subacutadu.pdf.
[64] 22 CCR section 51507.2
[65] 22 CCR section 51507.1
[66] 22 CCR section 51507

Included Services in Adult Subacute Per Diem Rate
Technical components of laboratory, pathology, and radiology[67]
Equipment and supplies for continuous intravenous therapy
Equipment and supplies necessary for debridement, packing and medicated irrigation with or without whirlpool treatment

Excluded Services in Adult Subacute Per Diem Rate
Allied health services ordered by the attending physician, excluding respiratory therapy
Alternating pressure mattresses/pads with motor
Blood, plasma and substitutes
Dental services
Durable medical equipment (DME), including custom wheelchairs, as specified in 22 CCR section 51321(h) (except as specified)
Insulin
Intravenous trays, tubing and blood infusion sets
Laboratory services (except as specified)
Legend drugs
MacLaren or Pogon Buggy
Medical supplies as specified in the list established by DHCS
Nasal cannula
Osteogenesis stimulator device
Parts and labor for repairs of DME if originally separately payable or owned by the Medi-Cal member
Physician services

[67] See the Medi-Cal Provider Manual, located at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=subacutadu.pdf.

Excluded Services in Adult Subacute Per Diem Rate
Portable aspirator
Precontoured structures (VASCO-PASS, cut out foam)
Prescribed prosthetic and orthotic devices for exclusive use of patient
Reagent testing sets
Therapeutic air/fluid support systems/beds
Transportation
Traction equipment and accessories
Variable height beds
X-rays (except as specified)
Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental.

Sources:

- 22 CCR section 51511.5
- Medi-Cal Provider Manual, Subacute Care Programs: Adult
- Medi-Cal Provider Manual, Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items

Additional Resources:

- Medi-Cal State Plan: Limitations on Attachment 3.1-B
- Medi-Cal State Plan: Attachment 4.19-D Methods and Standards for Payment Rates - Skilled Nursing and Intermediate Care Facility Services

Summary of Services Included in Pediatric Subacute Carve-In Per Diem Rate

Included Services in Pediatric Subacute Per Diem Rate
Summary: All services, equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria
Oxygen and all equipment necessary for administration including: • Positive pressure apparatus • Oxygen conserving devices (e.g., Oxymizer) • Nebulizers (e.g., Pulmoaide)
Ventilators, including humidifiers, in-line condensers, and in-line temperature measuring devices, calibration and maintenance
Feeding pumps and equipment necessary for tube feedings (nasogastric or gastrotomy), including formula.
Registered Dietician consultant services
Physical, occupational and speech therapy services provided within a supportive maintenance program[68] Note: Per the Medi-Cal Provider Manual, supportive or maintenance interventions included in the Pediatric Subacute per diem are therapy services that are part of routine daily care provided by nurses based on instructions from licensed therapists.[69] These interventions are part of the pediatric subacute level of care services (covered in the nursing facility's per diem rate) and, therefore, are not separately reimbursable.
Equipment and supplies necessary for the care of a tracheostomy, including tracheostomy speaking valves
Respiratory and inhalation therapy services administered by other than a physician
Equipment and supplies for continuous intravenous therapy
Developmental services

[68] 22 CCR section 51215.10(h)
[69] The Medi-Cal Provider Manual is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=subacutped.pdf.

Included Services in Pediatric Subacute Per Diem Rate
Service Coordinator activities
Portable imaging services provided by freestanding providers (for free-standing Pediatric Subacute facilities)
Unlisted supplies and materials used by physicians in non-surgical procedures (Current Procedural Terminology, CPT®, Code 99070)
Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory (CPT Code 99000)

MCPs must cover the following services with additional Prior Authorization approval, but these are not included in the Pediatric Subacute per diem rate:

- Supplemental rehabilitation therapy services: therapy services needed beyond the level of supportive or maintenance interventions, provided by a licensed therapist and require authorization.
- Ventilator Weaning Services.

Excluded Services in Pediatric Subacute Per Diem Rate
Alternating pressure mattresses/pads with motor
Blood, plasma and substitutes
Dental services
DME as specified in 22 CCR section 51321(h) (except as specified)
Insulin
Intravenous trays, tubing and blood infusion sets
Laboratory services (except as specified)
Legend drugs
MacLaren or Pogon Buggy
Medical supplies as specified in the list established by DHCS
Nasal cannula

Excluded Services in Pediatric Subacute Per Diem Rate
Osteogenesis stimulator device
Parts and labor for repairs of DME if originally separately payable or owned by the Medi-Cal member
Physician services
Portable aspirator
Precontoured structures (VASCO-PASS, cut out foam)
Prescribed prosthetic and orthotic devices for exclusive use of patient
Reagent testing sets
Therapeutic air/fluid support systems/beds
Traction equipment and accessories
Transportation
Variable height beds
X-rays (except as specified)
Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental.

Sources:

- 22 CCR section 51511.6
- Medi-Cal Provider Manual, Subacute Care Programs: Pediatric
- Medi-Cal Provider Manual, Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items

Additional Resources:

- 22 CCR section 51335.6
- 22 CCR sections 51215.5-51215.11
- Medi-Cal State Plan: Limitations on Attachment 3.1-B

- Medi-Cal State Plan: Attachment 4.19-D Methods and Standards for Payment Rates - Skilled Nursing and Intermediate Care Facility Services