CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Skilled Nursing 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.

Prior to January 1, 2023, the Medi-Cal LTC benefit was provided through Medi-Cal MCPs in the following counties:

- Del Norte, Humboldt, Lake, Lassen, Los Angeles, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Santa Clara, Trinity, Ventura, and Yolo.

In the remaining 31 counties, institutional LTC coverage by managed care plans (MCPs) was limited to the first month of admission and the following month. Members are disenrolled from the MCP to Medi-Cal Fee-for-Service (FFS) after the second continuous month of admission in a Skilled Nursing Facility.

Under CalAIM, institutional LTC is carved-in to Medi-Cal managed care in all counties. Effective January 1, 2023, all MCPs are responsible for the full LTC benefit at the following facility types and homes:

- Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital

Effective January 1, 2024, all MCPs became responsible for the full LTC benefit at the following facility types and homes:

- Intermediate Care Facility for Developmentally Disabled (ICF-DD);
- ICF-DD/Habilitative;
- ICF-DD/Nursing;

- Subacute Facility;
- Pediatric Subacute Facility

Note: ICF/DD-Continuous Nursing Care homes are not subject to the LTC Carve-In policy.

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 SNF LTC Carve-In and will be updated regularly. Please submit questions about the SNF LTC Carve-In to: LTCtransition@dhcs.ca.gov.

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

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SNF LTC Carve-In Frequently Asked Questions

CalAIM Implementation

1. **The stated goal of other Medi-Cal managed care initiatives has been to encourage community-based care – is that still the case?**

   Yes, the Department's goal is to keep as many beneficiaries out of institutional settings, and to transition as many beneficiaries from institutional settings to the community, as is possible, as long as they can safely live in the community with any necessary long-term services and supports determined to be medically appropriate.

2. ***(Updated December 2023)* Are adult and pediatric Subacute Care Facilities included in this transition?**

   Yes, both adult and pediatric Subacute Care Facility services are included in this transition effective January 1, 2024.

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

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

Benefits

4. **Which populations are subject to the SNF LTC Carve-In?**

   The SNF LTC Carve-In to managed care is determined by the facilities that individuals are residing in and their Medi-Cal eligibility status: Provider Type 17 Long Term Care and claim type code 02, including billing accommodation codes 01, 02, 03, 04, 05, 21, 22, 23, as defined in the LTC Accommodation Code to Revenue Code, Value Code and Value Code Amount Crosswalk.

5. **Are Special Treatment Programs (STPs) included in the SNF LTC Carve-In? E.g., will STP services be carved-in to managed care starting January 1, 2023?**

   An STP is a Skilled Nursing Facility (SNF) that has a mental health program approved by DHCS. SNF STPs are also considered an Institution for Mental Diseases (IMD) when more than half of their beds are designated for behavioral health and have more than 16 beds.

Non-IMD SNF STP services will remain carved out of Medi-Cal managed care and will continue to be paid for through Medi-Cal Fee-For-Service in 2023. The CalAIM SNF LTC Carve-In will not change how STPs operate today.

6. ***(Updated December 2023)*** **How will Medi-Cal Rx affect the LTC pharmacy benefit?**

   The LTC Carve-In policy does not make any changes to the coverage policies for pharmacy benefit coverage nor make any changes to Medi-Cal Rx. As stated in APL 22-012, coverage of Medi-Cal pharmacy benefits will vary. The financial responsibility for outpatient prescription drugs is determined by the claim type on which they are billed. If drugs are dispensed by a pharmacy and billed on a pharmacy claim, they are carved out of the managed care benefit and covered by Medi-Cal Rx.

   Note: 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, or any superseding APL, including recognizing OHC as the primary payer, and the Medi-Cal program as the payer of last resort. MCPs must coordinate benefits by exercising cost avoidance; billing OHCs, such as Medicare or private health coverage, as primary when the coverage is known; and conducting post-payment recovery for the reasonable value of the services if the OHC is identified retroactively, if the member has an OHC indicator of A, or if the service is required to be pay and chase.

   Additional information is available in APL 22-027, or any superseding APL. The existence of OHC must not be a barrier to accessing SNF services. More information on Crossover Claims can be found in the Crossover Claims Provider Toolkit and Medicare/Medi-Cal Crossover Claims: Long Term Care.

7. **For SNF residents, which drugs will be covered by Medi-Cal Rx versus an MCP?**

   If the 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 SNF and billed on a medical or institutional claim, the MCP is responsible. If a prescribing provider at the SNF determines a patient or resident requires treatment that is administered on site with a stock medication at the SNF (e.g., not ordered or filled by an outpatient pharmacy), this would be part of a medical visit claim and would not be covered by Medi-Cal Rx and is the responsibility of the MCP.

   For plans newly covering SNF services effective January 1, 2023 and for any other plan that does not include prescription drugs in their contracted SNF rates, all prescription drugs will be subject to the aforementioned rule regarding claim

type as the Medi-Cal FFS SNF facility rate does not include legend drugs (prescription drugs). MCPs may cover drugs that are not included in the MCP bundled rate for services provided by a SNF and not covered under Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered.

The website for Medi-Cal Rx is available here: Medi-Cal Rx Website.

More information on coverage of Medi-Cal pharmacy services through Medi-Cal Rx is available in the LTC section of the Provider Manual. Other FAQs on Medi-Cal Rx can be found here: Medi-Cal Rx FAQs.

8. ***(Updated December 2023)*** **What role does Medicare Part D play for dual-eligible residents in SNFs? How does Medi-Cal Rx coordinate with Medicare Part D?**

   For dual eligible members with Medicare Part D, medications will be billed against their Medicare benefits. Medi-Cal Rx coordinates benefits with Medicare Part D carriers using the Medi-Cal Rx eligibility system, pursuant to the Coordination of Benefits - Billing Medicare Part B and D Claims manual. Upon the submission of claims for Part D items, Medi-Cal Rx will adjudicate claims for products that are not covered or reject items that may be covered under Medicare Part D.

   More information on Crossover Claims can be found in the Crossover Claims Provider Toolkit and Medicare/Medi-Cal Crossover Claims: Long Term Care.

9. **How will an LTC facility get prior authorization from the MCP for non-emergency medical transportation (NEMT) and non-medical transportation (NMT) so that services are not interrupted?**

   Providers should work with their resident's MCPs to request NMT and NEMT transportation and obtain prior authorization, if applicable. For NEMT, a Physician Certification Statement form is required in order to obtain prior authorization. MCPs work with different transportation vendors to provide access to the appropriate transportation services for members.

10. ***(Updated April 2023)*** **How will the SNF LTC Carve-In affect hospice services and benefits?**

    The SNF LTC Carve-In does not affect the hospice benefit. Hospice care is currently a covered Medi-Cal managed care benefit and will continue to be after the SNF LTC Carve-In on January 1, 2023. APL 13-014, Hospice Services and Medi-Cal Managed Care, has more details on the hospice benefit for Medi-Cal members.

Transition and Care Coordination

11. Will MCPs be required to authorize Treatment Authorization Requests (TARs) for 12 months?

MCPs are responsible for honoring previously approved TARs for SNF services provided under the LTC per diem rate in Fee-for-Service for a period of 12 months after the member is enrolled in the MCP or for the duration of the treatment authorization, whichever is shorter, and until the MCP is able to reassess the member.

12. Will DHCS provide MCPs with a list of approved TARs for new members in advance of the January 1, 2023 transition?

DHCS will provide MCPs with transition data in November 2022. The transition data will consist of beneficiary-level demographic and claims-level data for each MCPs transitioning population, including utilization data and history such as TARs at the member Client Identification Number (CIN) level. The format of the MCP transition data will be the same as the June planning level data and is similar to the DHCS MCP All Payer Claims file.

13. *(Updated April 2023)* What will the TAR or authorization approval process look like after the January 1, 2023 SNF LTC Carve-in?

As outlined in APL 24-009, MCPs are responsible for covering services authorized under an existing DHCS approved SNF treatment authorization request (TAR) for a period of 12 months after a Medi-Cal member has enrolled in the MCP or for the duration of the treatment authorization, whichever is shorter, and until the MCP is able to reassess the member. After that initial 12-month period, the authorization approval timeframe is subject to prior authorization policies and procedures as established by MCP in accordance with rules and contract requirements governing utilization management, including prior authorization.

Effective January 1, 2023, MCPs are responsible for covering all open and active (e.g., unexpired) TARs. SNFs can make requests to MCPs for new authorizations beginning January 1, 2023. New authorizations are not required for beneficiaries transitioning from Medi-Cal FFS to a Medi-Cal MCP.

14. *(Updated December 2023)* Will beneficiaries who must pay Share of Cost (SOC) and are residing in SNFs be transitioned from FFS to managed care effective January 1, 2023?

Yes, all dual and non-dual-eligible individuals in long term care, including long term care SOC populations, will transition from Medi-Cal FFS to Medi-Cal managed care effective January 1, 2023. This does not apply to individuals in a

non-LTC aid code with a SOC. If a beneficiary with an LTC SOC aid code has not met their SOC, they will still be enrolled in an MCP, however their Health Care Plan (HCP) status code will show the member as not meeting SOC. Once the member meets their SOC, the HCP status codes are updated for capitation. Each SOC period starts again on the first of the following month.

15. ***(Updated December 2023)*** **Will SOC beneficiaries who are not currently residing in a SNF but become a resident of a SNF be transitioned from FFS to managed care?**

    Yes, managed care enrollment is based on aid codes. See Attachment 1 of APL 21-015, or any superseding APL, for more detailed information on Mandatory Managed Care Enrollment. SOC beneficiaries who will become residents of a SNF will be required to enroll in a Medi-Cal managed care plan.

    If a beneficiary is eligible for MCP enrollment based on their aid code, and if applicable based on the county they reside in, they will receive a choice packet to enroll in an MCP. They will have 30 days to choose a MCP and can contact Health Care Options for help enrolling in an MCP. Beneficiaries who have an LTC aid code and have a SOC are not able to be disenrolled from an MCP, unless they have an approved Medical Exemption.

16. ***(Updated December 2023)*** **How does admission and discharge from SNFs affect managed care enrollment for SOC beneficiaries?**

    Beneficiaries with a SOC LTC aid code residing in an SNF were carved-in to Medi-Cal managed care on January 1, 2023. Any beneficiary with a SOC aid code, but not an LTC aid code will remain in Fee-For-Service. The same policy applies to members with a SOC entering an LTC facility after 1/1/23.

    If a beneficiary is eligible for MCP enrollment based on their aid code, and if applicable based on the county they reside in, they will receive a choice packet to enroll in an MCP. They will have 30 days to choose an MCP and can contact HCO for help enrolling in an MCP. Members who have an LTC aid code and have a SOC are not able to be disenrolled from an MCP, unless they have an approved Medical Exemption.

    If a beneficiary with an LTC SOC aid code has not met their SOC, they will still be enrolled in an MCP, however their Health Care Plan (HCP) status code will show the member as not meeting SOC. Once the member meets their SOC, the HCP status codes are updated for capitation. Each SOC period starts again on the first of the following month.

17. ***(Updated October 2024)*** **If a beneficiary has a SOC, what are the SNFs' record keeping responsibilities?**

    SNFs are responsible for collecting SOC from members if SOC is indicated in the Medi-Cal eligibility verification system. SNFs 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 beneficiary may spend part of their SOC on medically necessary services, supplies, or equipment not covered by Medi-Cal. The SNF will need to subtract those amounts from a beneficiary's SOC and collect the remaining SOC amount owned. The expenditures from beneficiary'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 and a sample completed DHS 6114 form.

18. **Will a facility have any way of identifying which MCP a member will be enrolled to prior to January 1, 2023?**

    DHCS requires providers and MCPs to coordinate with one another to share data in order to facilitate a seamless transition for the members.

19. **Will providers continue to have the ability to login to the state Medi-Cal website to run single and batch eligibility on January 1, 2023?**

    Yes, providers will still have the ability to validate a single member or group of member's Medi-Cal eligibility on January 1, 2023.

20. **How will the January 1, 2023 SNF LTC Carve-In affect beneficiaries receiving services from a 1915(c) Home and Community-Based (HCBS) Waiver?**

    The SNF LTC Carve-In will not affect a beneficiary's HCBS Waiver coverage, services, or eligibility. Beneficiaries residing in a SNF for LTC cannot be concurrently enrolled in a 1915(c) HCBS Waiver but may be eligible and appropriate to transition back to the community and enroll in a 1915(c) HCBS Waiver. MCPs are required to coordinate transitions back to the community with HCBS Waiver agencies and/or providers.

21. ***(Updated April 2023)*** **How will the HCBS waiver programs coordinate with MCPs if their participants need to transition into a SNF-level of care after the January 1, 2023 Carve-In?**

    If a member is enrolled in an MCP while receiving services from a Medi-Cal Waiver program, the MCP shall continue to provide comprehensive case management and shall continue to cover all medically necessary covered services. Members transitioning to a SNF level of care will no longer be eligible to receive case management through an HCBS waiver program; therefore, the MCP

must ensure care coordination and care management include the coordination of facility transitions.

More information on individual HCBS waivers can be found on the Medicaid.gov webpage on Medi-Cal waivers and the DHCS webpage on Medi-Cal waivers.

22. **Please confirm that the Multipurpose Senior Services Program (MSSP) will not be included in the transition.**

    MSSP was carved out of managed care effective January 1, 2022, and will not be included in this benefit change.

23. **When does the 72-hour clock start for prior authorization requests for members who are transitioning from an acute care hospital?**

    Expedited authorizations are subject to a 72-hour timeframe, including weekends. Under APL 24-009, prior authorization requests for members who are transitioning from an acute care hospital must be considered expedited. The 72-hour timeframe begins as soon as the authorization request is submitted to the MCP.

24. **Will DHCS provide additional guidance on the care management and care coordination requirements for the LTC Carve-In?**

    Details on the Population Health Management (PHM) requirements are included in APL 24-009 and the Population Health Management Initiative webpage. Additional information about the PHM care management and care coordination requirements specific to members using SNF services is forthcoming.

25. ***(Updated December 2023)*** **What continuity of care protections exist for SNF residents that enroll in managed care after the January 1, 2023 transition and their current SNF is not in-network with their MCP?**

    To effectively comply with the continuity of care requirements set forth in APL 24-009, MCPs will need to contract with SNFs and also may need to offer single case agreements with a facility if not a contract. DHCS has also outlined MCP network adequacy and readiness requirements that include the requirement for MCPs to attempt to contract with all CDPH-enrolled and licensed SNFs in the MCPs' HEDIS Reporting Unit. Effective January 1, 2023, through June 30, 2023 members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed, MCPs must automatically provide 12 months of continuity of care for the SNF placement.

    MCP continuity of care requirements specific to the SNF LTC Carve-In are outlined in APL 24-009.

26. ***(Updated December 2023)*** **When a member is placed in a SNF in a county outside of where the MCP operates, is the member required to change MCPs?**

    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 SNFs outside of their county in order to appropriately meet member needs. For members in facilities out of county, MCPs may also work with those facilities to establish an interim letter of agreement (LOA). However, DHCS has informed MCPs that MCPs should seek to replace LOAs with network provider agreements.

27. ***(Updated December 2023)*** **How will the SNF LTC Carve-In affect Leave of Absences (LOAs) or Bed Holds? Are authorizations required for LOAs or Bed Holds?**

    The SNF LTC Carve-In will not affect coverage of LOAs or Bed Holds. APL 24-009 provides details on LOAs and Bed Holds.

    MCPs' policies and procedures outlining authorizations, if any, for LOAs and Bed Holds will vary. MCPs and providers are required to work together to ensure the policies and procedures specific to LOAs and Bed Holds are understood and comply with APL 24-009 and related requirements. The requirement in APL 24-009 to expedite prior authorization requests for members who are transitioning from an acute care hospital recognizes the importance of ensuring plans do not jeopardize a member's health. Auto-approvals or presumptive approvals of authorization requests for bed holds 7 days or under are encouraged.

28. ***(Updated December 2023)*** **What are the LOA and Bed Hold requirements and time limitations?**

    MCPs must ensure the provision of a LOA and/or Bed Hold that a SNF provides in accordance with the requirements of 22 CCR Section 72520 or California's Medicaid State Plan. MCPs must allow the member to return to the same SNF where the member previously resided under the LOA and/or Bed Hold policies in accordance with the Medi-Cal requirements for LOA and Bed Hold, which are detailed in 22 CCR Sections 51535 and 51535.1.

    Bed Holds are limited to a maximum of seven days per hospitalization. The facility must hold a bed vacant when requested by the attending physician, unless the attending physician notifies the SNF that the member requires more than seven days of hospital care. A facility cannot hold a bed after seven days and claims submitted for Bed Holds for more than seven days will be denied. Bed Holds must be ordered by a licensed physician and must not be followed by a discharge within 24 hours.

For Members who have been transferred from a SNF to a general acute care hospital, MCPs must ensure that Members have the right to return to the SNF 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 Title 42 Code of Federal Regulations (CFR) Part 483.15(e). In the event that a resident cannot return to the same facility, the facility must comply with transfer or discharge requirements (42 CFR 483.15(c)).

Please refer to the LOA, Bed Hold, and Room and Board section of the Provider Manual for more information.

29. Are facility Bed Holds or LOA payments subject to the SNF services and payment requirements?

Yes, Bed Holds and LOAs are subject to SNF services and payment requirements. Additional guidance on Bed Holds and LOA policies can be found in the LOA, Bed Hold, and Room and Board section of the Provider Manual.

30. *(Updated April 2023)* Who is authorized to request a Bed Hold or LOA on behalf of a member if they are unable to make the request themselves?

An LOA may be requested by a family member, caregiver, authorized representative, an LTSS Liaison, MCP care manager, or SNF case manager.

A Bed Hold must be ordered by a licensed physician, and must be in accordance with the individual recipient care plan and appropriate to the physical and mental well-being of the patient.

31. *(Updated April 2023)* Where can beneficiaries, caregivers, or providers find more information about LOA and Bed Holds?

General guidance for LOA and Bed Holds can be found in the LOA, Bed Hold, and Room and Board section of the Provider Manual. Specific questions about LOA and Bed Holds should be addressed directly to the MCPs. MCPs may have specific operations and procedures that must be followed for members to exercise their LOA and Bed Hold rights.

Payment and Rates

32. What is the State directed payment program?

Medi-Cal MCPs in transitioning counties are required to pay Network Providers of skilled nursing facility services, and Network Providers are obligated to accept, no more and no less than the State directed payment rates for applicable institutional SNF services. All other services outside the per diem rate are not subject to the directed payment policy and would follow the MCP and providers standard contract negotiation process.

As stated in APL 24-009, this reimbursement requirement only applies to SNF services as defined in 22 CCR Sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a member's stay. It does not apply to any other services provided to a member receiving SNF services such as, but not limited to, services outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d), services provided by an Out-of-Network Provider of SNF services, or services that are not provided by a Network Provider of SNF services. Such non-qualifying services are not subject to the terms of this State directed payment and are payable by MCPs in accordance with the MCP's agreement with the Network Provider.

33. ***(Updated April 2023)*** **What services within the SNF per diem rate are subject to the directed payment policy? What services are excluded from the SNF per diem rate?**

MCPs are required to pay the exact Medi-Cal FFS per diem rates for institutional SNF services as detailed in APL 24-009 in transitioning counties[1] where SNF services are a newly carved-in managed care covered benefit as of January 1, 2023. In non-transitioning counties[2] where SNF services are already managed care covered services, MCPs are required to pay no less than the Medi-Cal FFS per diem rates. Institutional SNF services that are excluded from the current FFS per diem rates are not subject to the direct payment requirements as specified in APL 24-009 and are payable by MCPs in accordance with the MCP's agreement with the provider.

The Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items section of the Provider Manual provides more detail on inclusive and exclusive items in the FFS per diem rate for SNFs.

Included Items: Items included in the FFS per diem rate are, as outlined in 22 CCR Sections 51123(a), 51511(b), 51535, and 51535.1:

- Room and board
- Nursing and related care services

[1] Newly transitioning counties for 2023 include the following counties: 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

[2] Counties with SNF services carved-in to Medi-Cal managed care in 2022 include the following counties: Del Norte, Humboldt, Lake, Lassen, Los Angeles, Marin, Mendocino, Merced, 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.

- All supplies, drugs, equipment and services necessary to provide a designated level of care (including incontinence supplies)
- Various personal hygiene items (denture cleaners, denture adhesives, dental floss, oral cleansing swabs, hair combs and brushes, lotions, shaving soap/cream, toothbrushes and toothpaste and tissue wipes for personal use, shaves or shampoos performed by facility staff as part of patience care and periodic hair trims)
- Therapy services provided to the recipient that are covered by the per diem rate include, but are not limited to:
    - Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
    - Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
    - Care to prevent formation and progression of decubiti, contractures and deformities, including:
        - Changing position of bedfast and chairfast recipients
        - Encouraging and assisting in self-care and activities of daily living
        - Maintaining proper body alignment and joint movement to prevent contractures and deformities

Excluded Items: Services excluded from the FFS per diem rate are all services outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d). Excluded services outlined in 22 CCR, Section 51123(b) and (c) are as follows:

- Allied health services ordered by the attending physician (including Optometry Services, Chiropractic Services, Psychology, Physical Therapy, Occupational Therapy, Speech Therapy, Audiology Services, Podiatry Services, Nurse Anesthetist Services)
- Alternating pressure mattresses/pads with motor
- Atmospheric oxygen concentrators and enrichers and accessories
- Blood, plasma and substitutes
- Chronic Hemodialysis
- Dental services
- Durable Medical Equipment as specified in CCR, Title 22, Section 51321(g)
- Early and Periodic Screening Services
- Eyeglasses, Prosthetic Eyes, and Other Eye Appliances
- Hearing Aids
- Home Health Agency Services
- Hospital Outpatient Department Services and Organized Outpatient Clinic Services, and Rehabilitation Center Outpatient Services (including Outpatient Heroin Detoxification Services)

- Inpatient Hospital Services
- Insulin
- Intermittent positive pressure breathing equipment
- Intravenous trays, tubing and blood infusion sets
- Items and services which are provided under State Department of Social Services regulations
- Laboratory services (including Radiological and Radioisotope Services)
- Legend drugs (including Pharmaceutical Services and Prescribed Drugs)
- Liquid oxygen system
- MacLaren or Pogon Buggy
- Medical Transportation Services
- Medical supplies as specified in the W&I Code, Section 14105.47
- Nasal cannula
- Osteogenesis stimulator device
- Oxygen (except emergency)
- Parts and labor for repairs of Durable Medical Equipment if originally separately reimbursable or owned by recipient
- Physician services
- Prayer or Spiritual Healing
- Portable aspirator
- Portable gas oxygen system and accessories
- Precontoured structures (VASCO-PASS, cut out foam)
- Prescribed prosthetic and orthotic devices for exclusive use of patient
- Reagent testing sets
- Renal Homotransplantation
- Short-Doyle Medi-Cal Provider Services
- Therapeutic air/fluid support systems/beds
- Therapy services that are provided by a licensed therapist, identified in the Minimum Data Set[3], included in the recipient's plan of care and prescribed by the recipient's physician
- Traction equipment and accessories
- Variable height beds
- X-rays

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[3]The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Centers for Medicare & Medicaid Services MDS 3.0 Public Reports are available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports.

34. *(Updated December 2023)* Under the directed payment policy, which therapy services are covered under directed payment, and which are not?

APL 24-009 states that transitioning counties must pay, and network provider furnishing SNF services must accept, the payment amount that the network provider would have been paid in the FFS delivery system (i.e., the FFS per diem rate). This is for all Institutional SNF LTC services covered under the per diem rate as defined in the CCR sections mentioned in the APL and the Medi-Cal Provider Manual.

Per the Medi-Cal Provider Manual, in many cases, therapy services needed to attain and/or maintain the highest practicable level of functioning can and should be performed as part of per diem inclusive services. Therapy services provided to the recipient that are covered by the per diem rate include, but are not limited to:

- Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
- Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
- Care to prevent formation and progression of decubiti, contractures and deformities, including:
    - Changing position of bedfast and chairfast recipients
    - Encouraging and assisting in self-care and activities of daily living
    - Maintaining proper body alignment and joint movement to prevent contractures and deformities

Therapy services outside the per diem rate are not subject to the directed payment policy and would follow the standard MCP and provider contract negotiation process. Therapy services outside the FFS per diem rates are separately payable. These services must be medically necessary, meaning a qualified provider must determine if a patient requires intensive therapy to attain or maintain the highest practicable occupational, mental, and psychosocial functioning in accordance with their individualized plan of care. An example includes therapy services that are provided by a licenses therapist identified in the recipient's plan of care and prescribed by the recipient's physician.

More detail and examples of inclusive and exclusive therapy services are available in the Medical Provider Manual sections titled Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items and TAR Criteria for NF Authorization (Valdivia v. Coye).

Note: 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, or any superseding APL,

including recognizing OHC as the primary payer, and the Medi-Cal program as the payer of last resort. See FAQ #6 for additional information.

35. ***(Updated April 2023)*** **What medications are excluded from the LTC facility per diem rate?**

Legend drugs and insulin are considered exclusive items (separately reimbursable) and are not included in the LTC facility per diem rate. CCR Title 22 Section 51313 (d) and 51550 (c) identifies the following services and supplies outside of the LTC facility payment rate and must be billed separately by a provider:

- Allied health services ordered by the attending physician
- Alternating pressure mattresses/pads with motor
- Atmospheric oxygen concentrators and enrichers and accessories
- Blood, plasma and substitutes
- Dental services
- Durable medical equipment as specified in Section 51321(g)
- Insulin
- Intermittent positive pressure breathing equipment
- Intravenous trays, tubing and blood infusion sets
- Laboratory services
- Legend drugs
- Liquid oxygen system
- MacLaren or Pogon Buggy
- Medical supplies as specified in the list established by the Department
- Nasal cannula
- Osteogenesis stimulator device
- Oxygen (except emergency)
- Parts and labor for repairs of durable medical equipment if originally separately payable or owned by the beneficiary
- Physician services
- Portable aspirator
- Portable gas oxygen system and accessories
- 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
- Variable height beds
- X-rays

The full list of items not included in the per diem rate for non-subacute patients in SNF facilities can also be found in the Medi-Cal Provider Manual.

36. **Are medications billed by outpatient pharmacies included in the LTC facility per diem rate?**

    If LTC facilities obtain prescription drugs for patients through an outpatient pharmacy, and these drugs are billed on a pharmacy claim, then they will be carved-out. More information can be found in the Medi-Cal Provider Manual.

37. ***(Updated April 2023)*** **Does the directed payment policy apply to both existing SNF residents and those that newly enter a facility on or after January 1, 2023?**

    Yes, the directed payment applies to all SNF residents in transitioning counties starting from day one of the stay. This includes existing SNF residents and newly admitted SNF residents as of January 1, 2023.

38. **Are Medi-Cal MCPs obligated to pay SNFs for both NF-A and NF-B levels of care?**

    Yes, MCPs are obligated to pay for all SNF levels of care, including custodial care, skilled nursing facility care (NF-B), intermediate care (NF-A). Intermediate care services are a Medi-Cal covered benefit and are the financial responsibility of MCPs.

39. ***(Updated December 2023)*** **Are there different FFS per diem rates for members receiving institutional LTC services through skilled vs custodial care?**

    No. The FFS per diem rates do not differ between skilled vs custodial care, which means it is a blended rate that is higher than the average custodial-only per diem rate and lower than the average skilled per diem rate. Ancillary services outside the FFS per diem rates are separately payable. Plans may negotiate payment rates for such services that are not subject to the directed payment policy. See responses earlier in this section for more information.

40. ***(Updated April 2023)*** **Due to the statewide SNF LTC Carve-In, are MCPs required to pay for administrative days if they cannot find a SNF placement to discharge a patient from the hospital?**

    Yes, MCPs are required to pay for the hospitalization of a member, including any administrative days in an acute care setting if a SNF placement following discharge cannot be found.

41. Will DHCS issue a standard Medi-Cal fee schedule for members receiving other levels of care or services?

No, DHCS will not issue a standard Medi-Cal fee schedule that MCPs must use for other services outside of the LTC per diem rate. Ancillary services outside of LTC services will continue to be negotiated and paid through the normal MCP and provider contract negotiation process.

42. Is the first 60 days of SNF LTC payments considered subject to the benefit standardization?

Yes. The benefit standardization carves in the SNF LTC benefit into managed care, therefore the first 60 days of SNF LTC facility payments currently covered by the MCP in transitioning counties are subject to the same payment requirements as for length of stays for day 60 or more.

43. If there are rate reductions on the FFS side, will those be made available in the same place as the FFS rates or will plans need to check elsewhere for the reductions?

Current rate reductions are available online as a part of the normal per diem rates for long-term care providers. Facility rates, including information on rate reductions, is posted on the DHCS webpage on Long-Term Care Reimbursement.

44. *(Updated October 2024)* When the FFS per diem rate is updated, when can SNF 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 SNFs, retroactively. MCPs are responsible for adjusting claims retroactively and issuing correct payments to SNFs within 45 Working Days after being notified of the published updated rate. MCPs must not require SNFs to resubmit claims as a result of the published updated per diem rate.

45. If an MCP wanted to incentivize or reward a SNF for providing higher quality care, for instance, by paying it above the State directed payment rate, would this be permissible? Is paying a SNF above the State directed payment rate allowed?

Reimbursement for services within the scope of the directed payment should be at the directed payment amount. However, any additional payment provided to

SNFs for services outside of the state directed payment will be appropriately built into the MCP's rates (i.e., separate from the per diem rate). Additional payments related to quality may be available to qualifying Network Providers through the Workforce and Quality Incentive program (WQIP), as authorized by Welfare & Institutions Code section 14126.024, subject to Centers for Medicare & Medicaid Services (CMS) approval and future budgetary authorization and appropriation by the California Legislature.

46. What supplemental payments, if any, are allowable for SNFs for hard-to-place members?

MCPs are required to pay an amount equal to the FFS per diem rates for institutional SNF services as detailed in APL 24-009 in transitioning counties where LTC is a new managed care covered benefit as of January 1, 2023. In non-transitioning counties where SNF services are already managed care covered services, MCPs are required to pay no less than Medi-Cal FFS per diem rates. Services outside of the scope of Institutional SNF services included in the FFS per diem rates are not subject to the direct payment direction specified in APL 24-009 and are payable by MCPs in accordance with the MCP's agreement with the network provider.

47. *(Updated December 2023)* For members in a SNF, is Total Parenteral Nutrition (TPN) included in Medi-Cal Rx and can it be billed directly by the pharmacy provider to Medi-Cal Rx?

Yes, Medi-Cal Rx covers TPNs for a maximum of 10 days' supply within 10 days of inpatient discharge without a prior authorization. Coverage outside of these parameters requires prior authorization. Please see the Provider Manual on Intravenous or Intra-arterial Solutions: Special Billing and the Medi-Cal Rx Provider Manual for more information.

48. *(Updated December 2023)* Can TPN be billed directly to Medi-Cal Rx for SNF members who only have Medi-Cal coverage and do not have Medicare Part B coverage?

Yes, TPN can be billed directly to Medi-Cal Rx. Based on the Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items document, TPN falls under exclusive items[4] not covered by the per diem rate and therefore

[4] Exclusive items are supplies, drugs, equipment or services not included in the per diem rate and are separately reimbursable subject to the utilization review controls and limitations of the Medi-Cal program for non-subacute patients in LTC facilities. Exclusive items include Durable Medical Equipment (DME) as specified in CCR, Title 22, Section 51321(g), intravenous trays, tubing and blood infusion sets, legend drugs, etc.

separately reimbursable. TPN should be billed directly to Medi-Cal Rx for SNF members who only have Medi-Cal coverage.

Quality Improvement

49. What are the "disqualifying quality-of-care issues" for SNFs and how are they determined?

As stated in APL 18-008, a disqualifying quality of care issue means the MCP can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MCP members.

MCPs must contract only with LTC facilities licensed by the California Department of Public Health (CDPH) that are enrolled in Medi-Cal. MCPs must ensure enrollment and credentialing of SNFs, in accordance with APL 19-004, Provider Credentialing/Recredentialing and Screening/Enrollment, or any superseding APL, before contracting with SNFs. DHCS will be providing further guidance for MCPs to monitor SNFs' regarding quality of care as aligned with the SNF WQIP initiative.

50. Will DHCS have new/additional quality or performance expectations (e.g., improved access, shorter lengths of stay, improved transitions)? If so, how will DHCS measure and monitor this?

MCPs will continue to be expected to meet all contractual responsibilities for ensuring member access and quality of care, including but not limited to ensuring the provision of preventive and wellness services, the provision of medically necessary services, and providing care coordination and case management to address member needs and improve health outcomes. DHCS expects MCPs will consider the needs of members in SNF LTC facilities as they design their PHM program, deploy appropriate resources for members based on continual assessments of risk and need, and continually reassesses the effectiveness of their PHM strategy.

DHCS will be clarifying quality and performance expectations that will impact the LTC Carve-In but these changes will be coordinated with other related DHCS initiatives, including the LTSS Dashboard (part of the HCBS spending plan), SNF WQIP (AB186) program, D-SNP transitions and other initiatives that impact this population. DHCS intends to align additional measures, where possible, and will issue further guidance when available.

51. Will there be new reporting requirements?

DHCS is evaluating specific data reporting related to the LTC Carve-In. As currently required, DHCS will conduct readiness activities pre-implementation and post-implementation monitoring after the go-live date.

52. Will DHCS use "lessons learned" or other evaluations of counties where LTC is already carved in? What are the best approaches for managing the benefit within Medi-Cal managed care? What are some improvements that are needed?

A significant number of Medi-Cal members residing in LTC facilities are already in counties with mandatory Medi-Cal managed care, including all COHS and CCI counties. DHCS has been working with Cal MediConnect plans, MCPs, and LTC facilities in CCI and COHS counties to provide lessons learned and best practices for plans during the LTC transition. A summary of the SNF LTC Carve-In requirements, promising practices, and model contract language will be shared in a forthcoming resource.

53. *(Updated October 2024)* What other initiatives are there on SNF quality and payments? Will they intersect with the SNF LTC Carve-In?

Authorized by Welfare & Institutions Code Section 14126.024 (added by Assembly Bill (AB) 186 (Chapter 46, Statutes of 2022)), the SNF Workforce and Quality Incentive Program (WQIP) incentivizes facilities to improve quality of care, advance equity in healthcare outcomes, and invest in workforce. SNF WQIP provides directed payments to facilities through the managed care delivery system and succeeds the former Fee-For-Service Quality and Accountability Supplemental Payment (QASP) program. SNF WQIP is authorized for dates of service January 1, 2023 through December 31, 2026.

DHCS published the final version of the SNF WQIP Technical Program Guide for PY2 (2024). Please note, public input is request and comments are due to DHCS by November 1, 2024. Policy letters to MCPs and SNF stakeholders can be found on the WQIP Program Polices and Directive Letters webpage. Payment Reports regarding the relevant SNF WQIP data sets will also be published on the WQIP Payment Reports webpage.

Additional details on SNF WQIP may be found here: https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx.

In addition, DHCS' Population Health Management Program includes numerous policies and requirements pertinent to improving quality and equity for members receiving LTC services, as well as the Enhanced Care Management program which intends to improve quality and equity outcomes for the LTC Population of Focus. DHCS will continue to work with plans on integration and alignment between these programs and the LTC Carve in.

Additional details on Population Health Management Program may be found here: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

Information on Enhanced Care Management may be found here: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx.

Policies and Procedures

54. *(Updated April 2023)* How often can Medi-Cal managed care enrollees change their plan?

Medi-Cal only members as well as dual eligible members who are not part of the Medi-Cal matching plan policy, that enrolled in a Medi-Cal MCP can change their Medi-Cal MCP on a monthly basis for any reason, and join a different MCP. This means that if a member chooses to change plans, their new selection will be active the first of the following month. The member or their Authorized Representative can contact Health Care Options (HCO): https://www.healthcareoptions.dhcs.ca.gov/en. Note: In certain counties, called County Organized Health Systems, the Medi-Cal plan is operated by the county. In those counties, there is only one Medi-Cal plan serving all members.

Dual Eligible, Medi-Cal Matching Plan Members: Most dual eligible beneficiaries (those enrolled in both Medicare and Medi-Cal) will be enrolled in a Medi-Cal MCP starting January 1, 2023. In certain counties, beneficiaries that are part of the Medi-Cal matching plan policy will be enrolled in a Medi-Cal MCP that matches their Medicare Advantage plan to ensure consistency and alignment of the delivery of their health care services. More information on the Medi-Cal matching plan policy is here: Medi-Cal Matching Plan Policy.

55. *(Updated April 2023)* What Medi-Cal MCPs will be available to members after the January 1, 2023 SNF LTC Carve-In?

Effective January 1, 2023, all MCPs are responsible for covering the SNF LTC benefit, including for freestanding and hospital-based SNF-based care. A list of all Medi-Cal MCPs available in each county can be found here: Medi-Cal Managed Care Health Plan Directory.

56. *(Updated April 2023)* What are the effective dates of Medi-Cal managed care enrollment for SNF LTC members?

For Medi-Cal Only Members and Members not part of the Medi-Cal matching plan policy: Beneficiaries that choose a Medi-Cal MCP prior to the MEDS cut-off date in December, their Medi-Cal managed care eligibility effective date will be January 1, 2023. Beneficiaries that do not choose a Medi-Cal MCP and their Medi-Cal MCP enrollment is defaulted, their Medi-Cal managed care enrollment effective date will be February 1, 2023. The default date is listed in the My Medi-Cal Choice packet received by the beneficiary in late November/early December 2023.

For Dual Eligible members part of the Medi-Cal matching plan policy: Beneficiaries will be enrolled in a Medi-Cal MCP starting January 1, 2023. In certain counties, beneficiaries that are part of the Medi-Cal matching plan policy will be enrolled in a Medi-Cal MCP that matches their Medicare Advantage plan to ensure consistency and alignment of the delivery of their health care services. More information on the Medi-Cal matching plan policy is here: Medi-Cal Matching Plan Policy.

57. *(Updated April 2023)* When and where can providers view Medi-Cal eligibility and health plan assignment for their members?

Medi-Cal member MCP assignments will be reflected in the Automated Eligibility Verification System (AEVS) on January 1, 2023.

58. *(Updated April 2023)* How does Medi-Cal plan matching work for dual eligible members affected by the SNF LTC Carve-In?

In the twelve Medi-Cal matching plan policy counties, beneficiaries impacted by the SNF LTC Carve-In will automatically be enrolled into the matching Medi-Cal plan that aligns with their existing Medicare coverage.

These 30 and 60 day notices and their accompanying Notice of Additional Information (NOAI) are available to view in English and Spanish on the DHCS SNF LTC Carve-In Webpage. See Question 50 for MCP effective dates.

59. What will the LTC Carve-In member communications and noticing look like?

Members residing in a SNF who are transitioning into managed care will receive a notice 60 and 30 days before January 1, 2023 from DHCS. The 60- and 30-day member notice will explain the transition to managed care, a beneficiary's options, what health plan they will be enrolled in, describe the continuity of care for residents and provide important phone numbers to let beneficiaries know where to call if they have questions. Each member notice will include a Notice of Additional Information (NOAI) that explains the LTC-Carve In and answers key questions that beneficiaries, authorized representatives or caregivers, and providers may have.

Health Care Options (HCO) will conduct outbound calls in December 2022 to the impacted members to ensure members understand the transition and MCP options.

60. What is the MCP's responsibility for oversight of LTC facilities?

MCPs will be responsible for ensuring that LTC facilities serving their members are licensed and certified, not excluded from participation in Medi-Cal, and for ongoing monitoring. MCPs will also be responsible for the monitoring of LTC

quality, in alignment with the CMS and DHCS requirements. DHCS will certify MCPs' provider networks to ensure that they have an adequate number of LTC facilities within their contracted service area. MCPs will also be required to submit new LTC specific policies and procedures and/or updates to existing policies and procedures incorporating the LTC benefit for review and approval. DHCS will validate a MCP's submissions to ensure they are accurate prior to the MCP having a certified network of LTC facilities.

61. ***(Updated December 2023)*** **What is the Grievance and Appeals (G&A) process for LTC services? 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.

62. ***(Updated April 2023)*** **Will the SNF LTC Carve-In affect the Medi-Cal grievance and appeal process? Will the grievance and appeals process be different for dual eligible members?**

No, the SNF LTC Carve-In will not impact the Medi-Cal grievance and appeals process.

For dual eligible members, up to the first 100 days of a skilled nursing facility stay may be covered by Medicare as the primary payer, and the Medicare grievance and appeals process would apply. For days not covered by Medicare, Medi-Cal would be the payer, and the Medi-Cal grievance and appeals process would apply. Grievances and appeals should be addressed to the entity that is the primary payer for the skilled nursing facility stay at the time that they are made.

Current guidance on Grievance and Appeal Requirements can be found in APL 21-011.

63. ***(Updated October 2024)*** **Will DHCS be providing more information on oversight and monitoring?**

DHCS' Audits and Investigations Division (A&I) is responsible for evaluating MCP compliance with the responsibilities outlined in the contract and APL. A&I will continue to audit MCPs based on their contract, which in many counties already includes LTC. The contracts have been updated to include LTC in counties where the LTC Carve-In has occurred. Additional oversight and monitoring guidance is forthcoming, including for expectations around quality improvement and quality assurance activities.

64. **Is APL 24-009 applicable to MCPs that are receiving UnitedHealthcare Community Plan's (UHC's) members due to its contract terminating in San Diego County effective December 31, 2022?**

Yes, MCPs that are receiving UHC's members in San Diego County due to UHC's contract expiring effective December 31, 2022 must comply with the requirements in APL 24-009.