DHCS
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 a new 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 will be enrolled in Medi-Cal managed care plans (MCPs), and those plans will 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 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. Today, 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 July 1, 2023, all MCPs will become 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 plans to offer 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: info@calduals.org

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

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. **Are subacute and pediatric subacute facilities included in this transition?**
   Medi-Cal managed care will become responsible for subacute and pediatric subacute facility services effective July 1, 2023, six months after SNFs are carved in.

   COHS counties currently provide subacute and pediatric subacute facilities as a Medi-Cal benefit, and will continue to do so after July 1, 2023. In non-COHS counties, LTC coverage in subacute and pediatric subacute facilities will be a new Medi-Cal benefit covered by the MCPs.

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 Medi-Cal Provider Manual: https://medi-cal.ca.gov/file/manual?fn=accomcdltc.pdf.

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. **How will Medi-Cal Rx affect the LTC pharmacy benefit? What does pharmacy benefit coverage look like for SNF residents? Which drugs will be covered by Medi-Cal Rx versus a Managed Care Plan (MCP) for SNF residents?**
   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.

7. **What does pharmacy benefit coverage look like for SNF residents? Which drugs will be covered by Medi-Cal Rx versus a MCP for SNF residents?**
   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. **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.

9. ***(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

10. **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.

11. **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.

12. ***(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 23-004,[1] 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 members has enrolled

[1] APL 23-004 supersedes APL 22-018.

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.

13. ***(Updated April 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, beneficiaries who are considered "Share of Cost" eligible and reside in a SNF are transitioned from Medi-Cal FFS to Medi-Cal managed care effective January 1, 2023.

14. ***(Updated April 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, a beneficiaries who are considered "Share of Cost" eligible and are living in the community but, due to a change in health care status, become residents of a SNF – these SOC beneficiaries will be required to enroll in a Medi-Cal managed care.

15. **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.

16. **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.

17. **How will the LTC facilities be informed about the change in the beneficiaries' MCP enrollment change?**
At a minimum, DHCS will issue a Provider Bulletin and News Flash on the Medi-Cal website informing providers of the overall change in MCP responsibility for beneficiaries in a LTC facility. DHCS is requiring MCPs to outreach to the providers and facilities impacted by the SNF LTC Carve-In to ensure that they are informed about this change. DHCS will be offering SNF Carve-In education

webinars beginning in October 2022 through February 2023. These will be open to the public, including providers.

18. **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.

19. ***(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 beneficiary is enrolled in a 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 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.

20. **Please confirm that the Multipurpose Senior Services Program (MSSP) will be not included in the transition.**
MSSP was carved out of managed care effective January 1, 2022 and will not be included in this benefit change.

21. **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 23-004, 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.

22. **Will DHCS provide additional guidance on the care management and care coordination requirements for the LTC Carve-In?**
Details on the Population Health Management requirements are included in APL 23-004 and the PHM Policy Guide. Additional information about the PHM care

management and care coordination requirements specific to members using SNF services is forthcoming.

23. ***(Updated April 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 23-004, MCPs will need to contract with SNFs and also may need to offer single case agreements with a facility if not a contract, unless the facility does not meet standards of care as set by the California Department of Public Health (CDPH). 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 23-004.

24. ***(Updated April 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 23-004 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 23-004 and related requirements.

25. ***(Updated April 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.

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

26. **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 Medi-Cal Provider Guide.

27. ***(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?**
A LOA may be requested by a family member, caregiver, authorized representative, an LTSS Liaison, MCP care manager, or SNF case manager.

A LOA or 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.

28. ***(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 Medi-Cal 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

29. **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 23-004, this reimbursement requirement only applies to SNF services as defined in 22 CCR Sections 51123(a), 51511(b), 51535,

and 51535.1, as applicable, starting on the first day of a member's stay. 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.

30. ***(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 23-004 in transitioning counties[2] where SNF services are is a newly carved-in managed care covered benefit as of January 1, 2023. In non-transitioning counties[3] 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 23-004 and are payable by MCPs in accordance with the MCP's agreement with the provider.

The Medi-Cal Provider Manual (Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items) 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
- 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

[2] 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
[3] 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.

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):

- 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 Welfare and Institutions Code (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[4], included in the recipient's plan of care and prescribed by the recipient's physician
- Traction equipment and accessories
- Variable height beds
- X-rays

31. ***(Updated April 2023)*** **Under the directed payment policy, which therapy services are covered under directed payment, and which are not?**
APL 23-004 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

[4] 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.

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. 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 Minimum Data Set, included 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).

32. ***(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.

33. **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.

34. ***(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.

35. **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.

36. ***(Updated April 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.

37. ***(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[5] in an acute care setting if a SNF placement following discharge cannot be found.

[5] Additional details on Administration Days can be found in the Provider Manual: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/admin.pdf

38. **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.

39. **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.

40. **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.

41. **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.

42. **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 23-004 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 23-004 and are payable by MCPs in accordance with the MCP's agreement with the network provider.

Quality Improvement

43. 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.

44. 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 beneficiary needs and improve health outcomes. DHCS expects MCPs will consider the needs of beneficiaries in SNF LTC facilities as they design their PHM program, deploy appropriate resources for beneficiaries 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.

45. 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.

46. 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 beneficiaries 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.

47. *(Updated April 2023)* What other initiatives are there on SNF quality and payments? Will they intersect with the SNF LTC Carve-In?
Assembly Bill (AB) 186 (Chapter 46, Statutes of 2022) establishes a new Workforce and Quality Incentive Program (WQIP) performance-based State directed payment under the managed care delivery system for Network Providers of SNF services. WQIP will provide directed payments to facilities through the managed care delivery system to succeed the former Fee-For-Service Quality and Accountability Supplemental Payment (QASP) program. AB 186 requires DHCS to establish the methodology, parameters, and eligibility criteria for the WQIP in consultation with representatives from the long-term care industry, organized labor, consumer advocates, and MCPs.

The WQIP design will be aligned with the DHCS Comprehensive Quality Strategy Guiding Principles. DHCS will work to align managed care quality and performance reporting with the quality measures which are being monitored at the facility level through the WQIP.

DHCS is focusing on developing the WQIP program design for CY 2023 and will be subject to federal approval to the Centers for Medicare & Medicaid Services (CMS) by December 31, 2022 to be effective for CY 2023.

Additional details may be found here: https://www.dhcs.ca.gov/services/medi-cal/Pages/Nursing-Facility-Financing-Reform-AB-186.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.

Policies and Procedures

48. *(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): www.healthcareoptions.dhcs.ca.gov. 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 beneficiaries.

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.

49. *(Updated April 2023)* What Medi-Cal MCPs will be available to beneficiaries 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.

50. *(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.

51. ***(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.

52. ***(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.

53. **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.

54. 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.

55. What is the Grievance and Appeals (G&A) process for LTC services? If a beneficiary 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.

Medi-Cal members can contact the LTC Ombudsman or the DHCS Medi-Cal Managed Care Ombudsman, the DMHC HMO Consumer Service, or file complaints with the California Department of Public Health.

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.

The Grievances and Appeals process is referenced in APL 21-011.

56. ***(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 beneficiaries?**
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.

57. **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 will be updated to include LTC in counties where the LTC Carve-In will be new in 2023. Additional oversight and monitoring guidance is forthcoming, including for expectations around quality improvement and quality assurance activities.

58. **Is APL 23-004 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 23-004.