State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

Skilled Nursing Facility Long-Term Care Carve-In
Frequently Asked Questions (FAQ)
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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, and those plans will cover and coordinate LTC in all counties in the state.

Currently, the Medi-Cal LTC benefit is provided through Medi-Cal managed care plans in the following 22 County Organized Health System (COHS) and seven Coordinated Care Initiative (CCI) 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) is 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 will be carved-in to Medi-Cal managed care in all counties effective January 1, 2023. At that time, all MCPs will become 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 (ICF)
- 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 managed care plans.

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 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://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/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 Managed Care Plan (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.

Transition and Care Coordination

9. **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.

10. **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.

11. **How will Share of Cost (SOC) beneficiaries not living in an LTC facility be carved-in to managed care if they need LTC services?**
    SOC beneficiaries in LTC aid codes will be part of Medi-Cal managed care. If a member with SOC in the community needs LTC services, they will move into an LTC facility/home and be required to enroll in a Medi-Cal managed care.

12. **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.

13. **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.

14. **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.

15. **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.

16. **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.

17. **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 22-018, 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.

18. **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 22-018 and the PHM Policy Guide. Additional information about the PHM care management and care coordination requirements specific to members using SNF services is forthcoming.

Payment and Rates

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

20. **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.

21. **Are Medi-Cal managed care plans 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.

22. **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.

23. **Are facility Bed Holds or Leave of Absence payments subject to the SNF services and payment requirements?**
    Yes, Bed Holds and Leave of Absences are subject to SNF services and payment requirements**.** Additional guidance on Bed Holds and Leave of Absence policies can be found in the Medi-Cal Provider Guide.

24. **Will the first 60 days of LTC facility payments fall under SNF services and payment requirements?**
    Yes, the first 60 days of LTC facility payments currently covered by the MCP in transitioning counties will fall under SNF services and are subject to the same payment requirements.

25. **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.

26. What is the State directed payment program?

Medi-Cal managed care plans 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 22-018, 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.

27. 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 managed care plan'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.

28. 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 22-018 in transitioning counties where LTC is a new managed care covered benefit as of 1/1/2023. 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 22-018 and are payable by MCPs in accordance with the MCP's agreement with the network provider.

Quality Improvement

29. 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.

30. 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.

31. Will there be new reporting requirements?

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

32. 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.

Policies and Procedures

33. 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 managed care plan options.

34. 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.

35. **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.

36. **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.

37. **Is APL 22-018 applicable to Managed Care Health Plans (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 22-018.