	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

Purpose:

To describe the Central California Alliance for Health (the Alliance) process for authorization requests for Long-Term Care (LTC) services.

Policy:

The Alliance ensures access to licensed LTC facilities for Medi-Cal members who meet the criteria for LTC services. These facilities may include:

1. Skilled Nursing Facilities;
2. Sub-acute Facilities (pediatric and adult); or
3. Intermediate Care Facilities/Developmentally Disabled Home (ICF/DD Home)

Refer to the member's Evidence of Coverage (EOC) to determine the LTC benefit.

Alliance members in need of Skilled Nursing Facility (SNF) LTC services are placed in health care facilities that provide the level of care most appropriate to the member's needs.


Definitions:

Intermediate Care/ICF/DD Home: A level of care that is less intensive than skilled nursing care but includes home services, professional services, ancillary services, and transportation services.

Long Term Care (LTC): For Medi-Cal members, LTC is defined as care in a facility for longer than the month of admission, plus one month.

Long Term Care is a "variety" of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can also be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care services help with activities of daily living, such as eating, bathing, dressing or moving about. Medicare does not pay for such care unless it is part of certain short-term stays following hospitalization. LTC in a SNF must be medically necessary nursing as defined by Title 22 Medi-Cal guidelines.

Skilled Nursing or Skilled Rehabilitation Services: A level of care needed by a member who does not require hospital acute care, but who requires skilled nursing care or skilled rehabilitation services.

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	


Skilled Nursing Care is care provided or supervised by Registered Nurses. Nurses provide direct care; manage, observe, and evaluate a patient's care; and teach the patient and his or her family caregiver. Examples include: administering IV medications, injections or enteral feedings; wound care; and diabetic teaching. Any service that could be done safely by a non-medical person without the supervision of a nurse is not considered skilled nursing care. Medicare covers home health skilled nursing care that is part-time and intermittent.

Sub-Acute Care: A license status and level of care needed by a patient who does not meet acute care criteria, but who requires more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility. Sub-acute patients are medically fragile and require special services, such as chronic ventilator management, inhalation therapy, tracheostomy care, parenteral nutrition, and complex wound management care.

Effective January 1, 2024, the Alliance will authorize and cover Medically Necessary adult and pediatric subacute care services (provided in both freestanding and hospital-based facilities). The Alliance will determine Medical Necessity consistent with definitions in 22 Code of California Regulations (CCR) sections 51124.5 and 51124.6, Welfare and Institutions Code (W&I) section 14132.25, and the Medi-Cal Manual of Criteria. Additionally, Members who are admitted into a Subacute Care Facility will remain enrolled in Medi-Cal managed care instead of being disenrolled to Medi-Cal FFS. The Alliance will ensure that Members in need of adult or pediatric subacute care services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, as outlined in the Alliance Contract and as documented by the Member's Provider(s), including facility professional, and ancillary services. The Alliance will ensure that if a member needs adult or pediatric subacute care services, they are placed in a health care facility that is under contract for subacute care with DHCS' Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

The Alliance will ensure that prior authorizations are rendered in a timely manner for all Members, and know when all Members are admitted, discharged, or transferred from facilities, including Subacute Care Facilities. The Alliance will ensure that all transitional care services (TCS) are completed for all high-risk Members, including assigning a single point of contact, referred to as a care manager to assist Members throughout their transition and ensure all required services are complete. The Alliance assigned care managers will ensure Member transitions to and from a Subacute Care Facility are timely and do not delay or interrupt any Medically Necessary services or care, and that all required TCS are completed. Effective January 1, 2024, the Alliance will ensure all TCS are completed for all Members.

The Alliance will provide network providers that allows placement within 7 business days for Santa Cruz County, 14 calendar days for Mariposa, Merced, Monterey, and San Benito counties. .

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	


Procedures:

Members may be admitted to a Long-Term Care Facility from a variety of outpatient or inpatient settings. The Primary Care Provider (PCP) and/or treating physician, in collaboration with facility discharge planning staff and the Alliance Utilization Management (UM), identifies the most appropriate level of care for the member and assures that the member is placed in a health care facility that provides the level of care that best meets the member's medical needs. These health care facilities include Skilled Nursing Facilities, Sub-Acute Facilities, Pediatric Sub-Acute Facilities, and ICF/DD Homes. Decisions regarding the appropriate level of care are based on the definitions set forth in Title 22, California Code of Regulations (CCR) Sections, 51215, and the criteria for admission set forth in Sections 51335, 51118, 51120, 51335.5, 51334, 51335.6, and referenced sections of 51003 (e). ICF/DD Home services are determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. An authorization request for LTC services is required when the member meets any of the following criteria:

1. Newly admitted to the facility;
2. Medicare benefits are exhausted;
3. Medicare or other healthcare coverage (OHC) denies LTC, readmitted to LTC from an acute care hospital or did not return to the LTC facility on or before day eight (8) of "bed hold days;"
4. Returned to the LTC facility from an approved leave of absence beyond the approved return date;
5. Newly eligible with the Alliance while residing in the LTC facility; and/or,
6. Change in level of care (e.g., ICF level to SNF level, SNF to ICF level of care, SNF level to LTC level).

Eligibility Requirements:

Members must meet eligibility requirements for the month of service. For Members with Other Healthcare Coverage (OHC) and Medicare, coordination of benefits will apply according to Alliance Policy 702-1750 – Coordination of Benefits Guidelines for Providers.

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

MEMBER IDENTIFICATION

Members in need of long-term care are identified by his/her physician, health care clinician, institution, UM Concurrent Review and/or Case Management (CM) staff who refers the member to the appropriate type of facility. The Alliance may assist with coordination in finding a facility for the appropriate level of care upon request, although primary responsibility remains with the hospital discharge planning staff. The Alliance may assist, as requested, with finding an appropriate Out-of-Network facility, where placement at an in-network facility is not available.

Availability of LTC Providers for the following counties must follow the required timeframes:

- a. Santa Cruz within 7 business days of request
- b. Monterey, Mariposa, Merced and San Benito within 14 business days of request

1. REFERRAL AND AUTHORIZATION REQUEST SUBMISSION


Referring physicians/facilities must submit the Authorization Request (Initial, Reauthorization or Retroactive-authorization) with the following documentation:

- a. A completed Pre-admission Screening / Pre-Admission Screening and Resident Review (PAS/ PASARR).
- b. The Minimum Data Set (MDS) and relevant medical record documentation supporting the medical necessity for the level of care requested.
- c. MC171(Medi-Cal LTC Facility Admission and Discharge Notification)
- d. A Medicare or other insurance denial, if applicable.

2. UM REVIEW AND DETERMINATION

Concurrent Review Nurses review requests for medical necessity and level of care. The Alliance covers all medically necessary services for Medi-Cal managed care members residing in or obtaining care in a SNF, including facility services; professional services; ancillary care services; and the appropriate level of care coordination.ⁱ

- a. Cases that do not meet criteria for medical necessity are referred to the Medical Director for review and determination. For more information on Medical Necessity, please see

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	


Alliance Policy 404-1112: Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests.

- b. Upon determination of medical necessity, an approval will be issued to the facility for up to one (1) year intervals or less, in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.


- a. Prior Authorization requests for members who are transitioning from an acute care hospital (skilled nursing/sub-acute) are considered expedited and a response will be provided within 72 hours, including weekends.

- i. Members who are admitted to a facility over a weekend are automatically approved for 3 days. If a member is admitted over a holiday weekend exceeding 2 calendar days, the member is automatically approved through the non-working days and reassessed the following business day.

- b.
 - i. Long-Term Care (LTC):
 - 1. Initial LTC Authorization Requests are approved for a maximum of six (6) months for contracted facilities and a maximum of three (3) months for non-contracted facilities, which allows for transfer of benefits to a new county.
 - 2. Reauthorizations for contracted facilities are approved for a maximum of one (1) year.
For members who have been identified or meet the criteria of "prolonged care", Prolonged Care classification recognizes that the medical condition of selected Members requires a prolonged period of skilled nursing care.
 - 3. Where members are found to not meet Title 22 criteria, (the authorization will be approved as modified.) Based on an individual members need up to one (1) month may be approved to allow for a safe discharge.
 - 4. Reauthorizations for members not meeting Title 22 criteria will be considered on an individual basis:
 - Reauthorization timeframes will be determined on an individual basis at a minimum of one (1) month and a maximum of three (3) months;

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

- Reauthorization may be subject to additional documentation from the requesting facility at the Alliance's discretion (i.e. documentation demonstrating appropriate discharge planning efforts); and,
 - Reauthorization may be denied should the facility fail to demonstrate appropriate discharge planning efforts.
 - 5. Utilization Management will oversee the Transitional Care Services (TCS), and know when all Members are admitted, discharged, or transferred from Skilled Nursing Facilities including Subacute Care Facilities. The Alliance will ensure that all TCS are completed for all high-risk Members, including assigning a single point of contact, referred to as a care manager, to assist Members throughout their transition and ensure all required services are complete. The Alliance and their assigned care managers will ensure Member transitions to and from a Skilled Nursing Facilities including Subacute Care Facility are timely and do not delay or interrupt any Medically Necessary services or care, and that TCS are completed. Effective January 1, 2024, The Alliance will ensure all TCS are completed for all Members.
- ii. Intermediate Care Services:
1. Initial authorization: approved for a maximum of six (6) months from date of admission.
 2. Authorization requests for ICF/DD Home services as determined through the IPP and Regional Center authorization, are authorized using the Certification for Special Treatment Program Services form HS 231. The Alliance must receive a copy of the Certification for Special Treatment Program Services form HS 231 as a prerequisite to providing coverage of ICF/DD Home services.
 3. Reauthorizations: approved for a maximum of one (1) year.
- iii. Skilled Nursing Facilities/Short Term Rehabilitative Services:
1. See Alliance Policy 404-1525 Skilled Nursing Program Policy for Medi-Cal.
- iv. Sub-Acute Care Services (Adult and Pediatric):
1. Initial Adult authorization: approved for a maximum of six (6) months. The Alliance will determine Medical Necessity for adult members consistent with the Medi-Cal Manual of Criteria following the definition in 22 Code of

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

California Regulations (CCR) section 51124.5. Medical Necessity for pediatric members may be found in 22 CCR section 51124.6 with supplemental requirements cited in the Welfare and Institutions Code (W&I) section 14132.25 and includes language to distinguish subacute care from skilled nursing or other types of long-term care services as well as eligibility criteria and treatment procedures. Additional information is included in the Medi-Cal Provider manual under Subacute Care Programs: Adult (subacute adult) and Subacute Care Programs: Pediatric (subacute pediatric)

2.


The Alliance will cover treatment authorization requests (TARs) for adult and pediatric subacute care services for services under the per diem rate, and inform the providers about which TAR forms are to be used and TAR forms must mention subacute care. DHCS provides detail on how LTC authorization requests are handled in Med-Cal FFS through the Medi-Cal Provider Manual as well as Information for Authorization/Reauthorization of Subacute Care Services - Adult Subacute Program (DHCS form 6200) and Information for Authorization/Reauthorization of Subacute Care Services - Pediatric Subacute Program (DHCS form 6200A).

3. Reauthorizations: approved for a maximum of one (1) year.

3. DENIAL NOTIFICATION AND COORDINATION OF CARE

A. Denials

- a. After the Medical Director review determines that Title 22 criteria is not met, UM staff ensures the member, provider, and facility are notified in writing of a denial for LTC, including the applicable appeal rights.
- b. In order to facilitate a safe discharge from the facility when a denial occurs, the Long Term Care Concurrent Review team will coordinate a Care Conference at the facility to discuss the appropriate discharge plan. Attendees may include the member, member representative, the facility staff, Ombudsman and CCAH staff. The Long Term Concurrent Review Team may consist of a Nurse and Social Worker. The purpose of the care conference is to identify barriers to discharge and resources available early in the discharge process to ensure a safe transition. The responsibility of the discharge remains with the facilities.
- c. The Alliance will comply with the discharge requirements in Health and Safety Code (H&S) section 1373.96 and W&I section 14186.3(c)(4).

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

- d. When the member does not meet the criteria for long-term care or if placement is not available, the UM staff continues to assist the PCP in managing the case and authorizes all medically necessary services. The PCP/attending physician continues to coordinate treatment for the member.
- e. The UM/ staff coordinates the benefits with the facility and notifies the member and requesting provider when benefits are exhausted for non-Medi-Cal members who may have limited or no benefits according to their individual Evidence of Coverage (EOC).
- f. Reauthorization will be considered on an individual basis if a safe discharge is not anticipated.

B. Post-Discharge Transitional Care Services

- a. Members who are discharged from a facility are followed for a period of 30 days post-discharge by the Alliance's UM Concurrent Review Team.
- b. Transitional Care Services (TCS) are provided to all high-risk members, including assigning a single point of contact to assist members throughout their transition and ensure all required services are completed. The UM Concurrent Review Team identifies and makes referrals for members in need of additional support with transitions of care beyond 30 days to Enhanced Care Management (ECM) or Complex Care Management (CCM), as appropriate.


4. CONTINUING CARE DETERMINATIONS

The Alliance provides continuity of care for members that are transferred from a SNF to a general acute care hospital, and then require a return to a SNF level of care due to medical necessity. Requirements regarding leave of absence, bed hold, and requirements outlined in Alliance Policy 404-1114 – Continuity of Care apply.

If for any reason a member is unable to access continuity of care as requested, the Alliance will provide the member or their authorized representative, and the facility in which the member resides, with a written notice of action of an adverse benefit determination per APL 21-011.

COC/Subacute

Effective January 1, 2024, through June 30, 2024, for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, the Alliance automatically provides 12 months of continuity of care for the Subacute Care Facility

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

placement. Automatic continuity of care means that if the Member is currently residing in a Subacute Care Facility, they do not have to request continuity of care to continue to reside in that facility. While Members must meet Medical Necessity criteria for adult or pediatric subacute care services, the Alliance automatically ensures the provision of continuity of care.

The Alliance will determine member eligibility for CoC before transition by identifying the member's current residency and pre-existing relationships through the review of utilization data or from documentation provided by the member or provider.

A pre-existing relationship means that the Member has resided in the SNF at some point during the 12 months prior to the date of the Member's enrollment with The Alliance..

Effective January 1, 2023, through June 30, 2023, for Members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, The Alliance was required to automatically provide 12 months of continuity of care for the SNF placement. Automatic continuity of care means that if the Member is currently residing in a SNF, they do not have to request continuity of care to continue to reside in that SNF. While Members must meet Medical Necessity criteria for SNF services, continuity of care must be automatically applied.


During the continuity of care period, The Alliance must automatically provide 12 months of continuity of care for the Subacute placement of any member residing in an ICF/DD Home who is mandatorily enrolled with The Alliance after January 1, 2024.

The Alliance will allow Members to stay in the same Subacute Care Facility under continuity of care if all of the following apply:

- The facility is contracted or actively in the process of being contracted by DHCS' SCU;
- The facility is enrolled and licensed by CDPH;
- The facility is enrolled as a Medi-Cal Provider;
- The Subacute Care Facility and the Alliance agree to payment rates; and
- The facility meets the Alliance applicable professional standards and has no disqualifying quality-of-care issues.

In cases where a member is unable to access CoC as requested, the Alliance will provide a Notice of Action (NOA) to the member and their respective facility.

Effective January 1, 2024, for members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, The Alliance will cover treatment authorization requests (TARs) that are approved by DHCS and provided under the Subacute Care Facility per diem rate for a period of six months after enrollment or for the duration of

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

the TAR approval, whichever is shorter. The Alliance will honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, authorized representative, or Provider in accordance with the requirements in APL 23-022, or any superseding APL.

Supplemental rehabilitation therapy services and ventilator weaning services may be separately authorized and reimbursed for eligible pediatric subacute patients. Reimbursement for these services is in addition to the per diem rate for pediatric subacute level of care services. An approved TAR is required for these services and is the responsibility of the nursing facility.


Effective January 1, 2024, for pediatric Members residing in a Subacute Care Facility who are transitioning from Medi-Cal FFS to Medi-Cal managed care, The Alliance will cover supplemental rehabilitation therapy services and ventilator weaning services for TARs approved by DHCS in a Subacute Care Facility for a period of three months after enrollment. The Alliance will honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, authorized representative, or Provider in accordance with the requirements in APL 23-022, or any superseding APL.

COC/ICF-DD Homes

ICF/DD Homes are a long-term home living setting, in which Members may spend months, years, or decades of life. It is not within the scope of The Alliance to change these living arrangements unnecessarily. Continuity of care ensures that a Member's ICF/DD Home will not change for at least 12 months while The Alliance works to bring the ICF/DD Homes into their Network. During the continuity of care period, The Alliance must automatically provide 12 months of continuity of care for the ICF/DD Home placement of any Member residing in an ICF/DD Home who is mandatorily enrolled with The Alliance after January 1, 2024.

Automatic continuity of care means that Members currently residing in an ICF/DD Home do not have to request continuity of care to continue to reside in the ICF/DD Home. Instead, The Alliance must automatically initiate the continuity of care process prior to the Member's transition. The Alliance must determine if Members are eligible for automatic continuity of care before the transition by identifying the Member's ICF/DD Home residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or Provider, if not otherwise available from DHCS. DHCS will provide beneficiary utilization and treatment authorization request (TAR) data to The Alliance in November 2023.

While Members must meet Medical Necessity criteria for ICF/DD services, continuity of care must be automatically applied. Medical Necessity is determined by documentation reflecting

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

current care needs and recipient's prognosis by the Regional Center. The HS 231, DHCS 6013 A and Treatment Authorization Request (TAR) form (LTC TAR 20-1) are considered sufficient information to determine Medical Necessity; however, if documentation is lacking, the Alliance must request additional supporting documents to substantiate Medical Necessity.

The Alliance must allow Members to stay in the same ICF/DD Home under continuity of care if the Member chooses to continue living in the ICF/DD Home and all of the following apply:

- The ICF/DD Home is licensed by CDPH;
- The ICF/DD Home is enrolled as a Medi-Cal Provider;
- The MCP will pay the ICF/DD Home payment rates that meet state statutory requirements; and
- The ICF/DD Home meets the Alliance applicable professional standards and has no disqualifying quality-of-care issues.


a. Regular Extensions

- i. Extensions of stay in SNFs for Medi-Cal members require reauthorization by the Alliance on a case-by-case basis and are approved in accordance with the time limitations as outlined in Title 22, CCR: Sections 51334, 51335, 51335.5 and 51335.6 for newly admitted members who may be eligible to return home.
- ii. For members residing in a facility and transitioning from Medi-Cal Fee-For-Service (FFS) to the Alliance, the Alliance is responsible for treatment authorization requests (TARs) approved by DHCS for SNF services provided under the per diem rate for a period of 12 months after enrollment in the Alliance, or for the duration of the TAR, whichever is shorter. Services exclusive of the per diem rate will be approved for a period of 90 days after enrollment, or until the Alliance is able to reassess the member and ensure provision of medically necessary services.
- iii.

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


b. Bed Holds

- a. The Alliance ensures the provision of a leave of absence (LOA)/bed hold by a Subacute Care Facility in accordance with the requirements of 22 CCR section 72520 and California's Medicaid State Plan. The Alliance will allow the Member to return to the same Subacute Care Facility where they previously resided under the LOA/bed hold policies subject to Medical Necessity in accordance with the Medi-Cal requirements for LOA and bed hold, which are detailed in 22 CCR sections 51535 and

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

51535.1. MCPs must ensure that a Subacute Care Facility notifies the Member or the Member's authorized representative in writing of the right to exercise the bed hold provision.

- b. In a similar protection for Members who have been transferred from a Subacute Care Facility to a general acute care hospital, The Alliance will ensure that Members have the right to return to the Subacute Care Facility and to the same bed, if available, or at a minimum to the next available room in the facility, regardless of the duration of the hospitalization, pursuant to 42 Code of Federal Regulations (CFR) section 483.15(e).
- c. The Alliance periodically reviews all bed holds, where trends are identified. The Alliance provides transition assistance and care coordination for members transitioning to a new facility when the facility where the member previously resided claims an exception under bed hold regulations, or fails to comply with regulations.ⁱⁱ
- d. The Alliance covers the stay when Members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then require a return to an ICF/DD Home.
- e. The Alliance authorizes any LOA or bed hold that an ICF/DD Home provides.
- f. The Alliance authorizes up to 73 days per calendar year for a LOA. For a bed hold, The Alliance authorizes up to a total of 7 days per hospitalization.
- g. The Alliance allows the Member to return to the same ICF/DD Home where the Member previously resided if it is the Member's preference. The Alliance will ensure the ICF/DD Home notifies the Member or the Member's authorized representative in writing of the right to exercise the bed hold provision. If Member does not wish to return to the same ICF/DD Home following a LOA or approved bed hold period, the Alliance will provide care coordination and transition support, including working with the assigned Regional Center, in order to assist the Member to identify another ICF/DD Home within the Alliance's Network that can serve the Member. The Regional Center will take the lead on discharge and transition planning if the Member wishes to transition to a Regional Center funded living situation with input from other stakeholder such as the hospital, the original ICF/DD Home, and the Alliance. The Alliance will take the lead on discharge and transition planning if the Member chooses to transition to a different Medi-Cal level of care.
- h. The Alliance will cover all Medically Necessary services for Medi-Cal managed care Members residing in or obtaining care in a SNF, including facility services; professional services; ancillary services; and the appropriate level of care coordination, including for carved-out Medi-Cal services, as outlined in this APL.
- i. The Regional Center service coordinator is the primary person interacting with the Member for the purpose of ensuring the Member receives the Regional Center funded services and supports identified in the IPP. They have lead administrative authority for facilitating living arrangements including ICF/DD Home arrangements. A

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

Member's expression of interest in seeking services from a different ICF/DD Home must not result in expulsion from the previously serving ICF/DD Home.

- j. Following initial 12-month continuity of care period, Members or their authorized representatives may request an additional 12 months of continuity of care, pursuant to the process established by APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, on or after January 1, 2023, or any superseding APL. The Alliance will notify the Member, or their authorized representative, and furnish a copy of the notification to the Subacute Facility or ICF/DD Home in which the Member resides, of the Member's right to request continuity of care, consistent with APL 23-022, and APL 23-027 or any superseding APL.
- k. Effective January 1, 2023, The Alliance in all counties will authorize and cover medically necessary SNF services (provided in both freestanding and hospital based facilities), consistent with definitions in the Medi-Cal Provider Manual and any subsequent updates. The Alliance will ensure that Members in need of SNF services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, as outlined in The Alliance contract and as documented by the Member's Provider(s). This means that, effective January 1, 2023, Members who are admitted into a SNF will remain enrolled in managed care instead of being disenrolled from The Alliance and enrolled in FFS Medi-Cal.
- l. The Alliance will ensure that the Subacute Care Facility and its staff have appropriate training on LOA and bed hold requirements, including knowledge of the required clinical documentation to exercise these rights.

5. CONTRACTUAL OBLIGATIONS


- a. Any contracted facility accepting a LTC member must comply with all contractual agreements with the Alliance, including but not limited to matters that fall under California State Welfare and Institutions codes 15630-15632: Mandatory and Non-mandatory Reports of Abuse.
- b. The Alliance will ensure that members have continued access to services including a contract -termination.

References:

Alliance Policies:

404-1112 – Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests

404-1114 – Continuity of Care

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

404-1525 – Skilled Nursing Program Policy for Medi-Cal
702-1750 – Coordination of Benefits Guidelines for Providers
404-1743 - Intermediate Care Facility/Developmental Disabled Homes

Impacted Departments:

- Claims
- Finance
- Member Services
- Provider Services

Regulatory:

- California Code of Regulations: Title 22, Sections 51118, 51120, 51120.5, 51121, 51123(a) 51124, 51124.5, and 51124.6, 51334, 51335, 51335.5, 51335.6, and referenced sections of 51003 (e), 51511(b) 51535, 51535.1, 72520
- 42 Code of Federal Regulations (CFR) section 483.15(e)

Legislative:

- California Welfare and Institutions Code, Section 15630 – 15632

Contractual (Previous Contract):

- DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provisions 10 & 11
- DHCS Medi-Cal Contract, Exhibit A, Attachment 18, Provision 11.X.1
- DHCS Medi-Cal Contract, Exhibit E, Attachment 1, Definitions, “Covered Services”
- DHCS Medi-Cal Contract, Exhibit E, Attachment 3, Provision 5

Contractual (2024 Contract):

- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.7.G
- Medi-Cal Contract, Exhibit A, Attachment 3, Provision 3.2.3


DHCS All Plan Letter:

- APL 22-018 – Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-022 Continuity of Care (CoC) for Medi-Cal Beneficiaries who newly enroll in Medi-Cal Managed Care from Fee-for-Service (FFS)
- DHCS APL 23-023 – Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- DHCS APL 23-027 - Subacute Care Facilities - LTC Benefit Standardization and Transition of Members to Managed Care
- DHCS APL 24-009 - SKILLED NURSING FACILITIES -- LONG TERM CARE BENEFIT STANDARDIZATION AND TRANSITION OF MEMBERS TO MANAGED CARE
- DHCS APL 24-010 - Subacute Care Facilities - LTC Benefit Standardization and Transition

NCQA:

Supersedes:

Other References:

	POLICIES AND PROCEDURES
Policy #: 404-1524	Lead Department: Utilization Management
Title: Long-Term Care for Medi-Cal Members	
Original Date: 03/01/2009	Date Published: 03/17/2025
Approved by: Utilization Management Work Group (UMWG)	

Attachments:

Lines of Business This Policy Applies To

- ☐ DSNP
☒ Medi-Cal
☐ Alliance Care IHSS

LOB Effective Dates

(01/01/2026 – present)
(01/01/1996 – present)
(07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
02/08/2023	02/09/2023	Paige Harris, Regulatory Reporting Supervisor	UMWG
2/23/2024	2/23/2024	Danah Hernandez, Regulatory Reporting Supervisor	UMWG
6/20/2024	6/21/2024	Viki Doolittle, UM Manager - Concurrent Review (RN)	UMWG
10/14/2024	10/14/2024	Viki Doolittle, RN UM Manager – Concurrent Review	UMWG
12/06/2024	12/06/2024	Danah Hernandez, Regulatory Reporting Supervisor	UMWG
02/14/2025	02/14/2025	Kelly Tlemcani, Business Analyst II	UMWG

ⁱ DHCS APL 22-018 – Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care

ⁱⁱ DHCS APL 22-018 – Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care