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SAN FRANCISCO HEALTH PLAN

CO-02 Skilled Nursing and Custodial Long-Term Care Admissions

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	4/22/2025	Policy Update
Signed by: Steve O'Brien 60DFB20814944C4...	CMO	4/22/2025	

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SFHP POLICY AND PROCEDURE

Skilled Nursing and Custodial Long-Term Care Admissions

Policy and Procedure Number:	CO-02
Department:	Clinical Operations
Accountable Lead:	Clinical Operations Analyst
Lines of Business Affected:	☒Medi-Cal ☐Medicare Advantage D-SNP ☐Healthy Workers HMO ☐Healthy SF ☐City Option ☐All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) authorizes and covers medically necessary Skilled Nursing and Custodial Care services. Skilled nursing care refers to skilled nursing or rehabilitation services, provided by a licensed professional. Custodial care refers to services provided by non-licensed care givers.

- Effective January 1, 2023, SFHP assumed responsibility of the Skilled Nursing Facility (SNF) Long-Term Care (LTC) benefit, previously managed by Fee-For-Service (FFS) Medi-Cal.
- Effective January 1, 2024, SFHP assumes responsibility of the Adult and Pediatric Subacute and Intermediate Care Facility for the Developmentally Disabled (ICF/DD) LTC benefit, previously managed by FFS Medi-Cal.

Non-dual and dual (members with both Medicare and Medi-Cal coverage) LTC residents (including those with a Share of Cost) will enroll in SFHP and remain enrolled instead of being disenrolled and transferred to FFS Medi-Cal. The payor transition does not impact members Medicare and/or Medi-Cal benefit coverage.

LTC is defined as care in a facility for an extended period of time, for a member with a long-term disposition, that exceeds the month of admission and month after. LTC SNF and Subacute admissions must meet Title 22 Code of California Regulations (CCR) Sections 51118, 51120, 51120.5, 51121, 51124, 51124.5, and 51124.6, and the criteria for admission set forth in Sections 51335, 51118, 51120, 51335.5, 51334, 51335.6, and referenced sections of 51003 (e), Welfare and Institutions Code (W&I) section 14132.25, and the Medi-Cal Manual of Criteria.. LTC ICF/DD admissions must meet Regional

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Center guidelines. For SNF and Subacute admissions, SFHP is responsible for medical necessity authorization review. For ICF/DD admissions, authorization responsibility is shared between SFHP and the Regional Center.

SFHP is responsible for all administrative aspects of LTC.

- SNF and Subacute admissions that do not exceed the month of admission and month after, do not have a long-term disposition, or that do not meet criteria will remain the responsibility of the delegated group to which the member is assigned. When the SNF or Subacute admission meets criteria and exceeds the month of admission and month after, members who are eligible and pre-authorized for custodial LTC, are reassigned to the SFHP Direct Network (SDN). The effective date of reassignment will be the first day of the third month of admission.
- ICF/DD admissions, authorized by the Regional Center, are SFHP's responsibility. Members are reassigned to the SDN Network immediately upon admission.

Members remain assigned to SDN through the entirety of their LTC admission.

SFHP is responsible for approved LTC, ICF/DD and adult & pediatric subacute FFS treatment authorization requests (TARs) and TARs for services exclusive of the LTC, ICF/DD and adult & pediatric subacute per diem rate for the duration of the TAR and until SFHP is able to reassess the member and authorize and connect the member to medically necessary services. Providers should refer to the Medi-Cal Provider Manual for more information about which TAR forms are to be used for subacute care.

SFHP provides automatic continuity of care to LTC, ICF/DD and Subacute members who meet medical necessity criteria and are undergoing the mandatory transition into SFHP for up to 12 months post-enrollment. SFHP determines appropriateness of automatic continuity using FFS utilization data. Following their initial 12-month continuity of care period, members may request an additional 12 months of continuity of care.

SFHP covers all medically necessary services for members residing in or obtaining care in a LTC, ICF/DD or Subacute facility including facility services, professional services, ancillary services, transportation, and the appropriate level of care coordination.
For pediatric and subacute care, SFHP determines 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. SFHP also follows the eligibility criteria and treatment procedures for adult and pediatric subacute care outlined in the Medi-Cal Provider Manual.

SFHP provides and covers medically necessary services through Out-of-Network Providers, including allowing access for the completion of Covered Services by an Out-of-Network Provider or terminated Provider, if medically necessary services are not available in-network.

SFHP reviews authorization requests for medical necessity for both Medi-Cal and dual eligible members. While Medicare covers qualified skilled care admissions as the primary

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payor, custodial LTC is not a covered benefit of Medicare. If/when the admission does not qualify for Medicare coverage (e.g., custodial care, no qualifying 3-day hospitalization, exceeds annual benefit limit, ICF-DD), SFHP assumes responsibility for medically necessary services.

PROCEDURE

SFHP strives to ensure members in need of skilled nursing and custodial care services are placed in a facility that provides the level of care most appropriate for the members' medical needs unless the member has elected hospice care. Members can be admitted to SNF, Subacute, and ICF/DD (hereafter referred as LTC facilities) from acute inpatient settings, transition from skilled levels, or as direct admits from the community. If/when placement in a medically necessary appropriate facility is not available, SFHP covers a member stay in a facility with availability regardless of medical necessity, unless otherwise specified by contract. SFHP works with referring providers to ensure members are placed in LTC facilities that are licensed and certified by the CDPH. SFHP also ensures that members who need adult or pediatric subacute care services 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.

A. **Authorization Requirements**
   1. Prior authorization is required for all LTC facility admissions unless the member has elected hospice care (see CO-32 Hospice Policy for hospice authorization procedures). This includes skilled nursing, custodial care, subacute and ICF/DD admissions.
   2. **Medi-Cal Only Members.** SFHP requires prior authorization from the provider before the date of admission. Referring providers must refer to all of SFHP's contracted providers. If the contracted providers are not available, a letter of agreement (LOA) may be initiated if requested by a non-contracted facility that agrees to accept the member.
   3. **Dual Eligible (Medicare – Medi-Cal) Members.** Medicare A covers the first 20 days of a qualified SNF admission at 100%. SFHP covers the co-insurance for days 21 to 100. Medicare B covers some skilled nursing care but does not cover room and board or certain nurse provided services. For Medicare covered admissions, SFHP requires notification following the admission. When Medi-Cal is the payor, SFHP requires clinical documentation for medical necessity. Only Medicare-certified SNFs can accept and admit dual eligible members for skilled nursing care.
      a. **Custodial Care:** Medicare covers skilled care only. If a member no longer requires skilled care and is transitioning to custodial care, Medicare will issue a Notice of Medicare Non-coverage (NOMNC) indicating last day of coverage. SFHP will assume primary coverage responsibility for the custodial care. SFHP creates custodial care authorizations when a NOMNC is received.

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

b. **Benefit Exhaustion:** Medicare covers up to 100 days of skilled care. If a member exhausts their benefit limit, Medicare will issue an Advance Beneficiary Notice of Non-coverage (ABN) indicating the last day of coverage. SFHP will assume primary coverage responsibility for the LTC. SFHP creates LTC authorizations when an ABN is received.
c. **Co-Insurance**: No authorization is required for Medicare A Co-Insurance. Claim submissions must include a Medicare Remittance Advice (RA) and/or Explanation of Benefits (EOB).
d. **Medicare B primary:** Per Medicare billing guidelines, Medicare B covers therapy and some diagnostic services, but does not cover room and board or certain nurse provided services. Room and board and nursing services not covered by Medicare is the responsibility of SFHP. Prior authorization is required for payment of these services.
e. **ICF/DD**: Medicare does not cover LTC ICF/DD Home benefits. LTC ICF/DD Home benefits are exclusively covered by Medi-Cal. ICF/DD Homes are not enrolled in Medicare, and do not bill Medicare for LTC ICF/DD Home benefits they provide.

B. **Criteria for Admission.**
1. **Skilled Nursing Care.** SFHP reviews skilled nursing admission requests utilizing MCG criteria (see CO-57 Clinical Criteria).
2. **LTC.** SFHP reviews long-term care admission requests utilizing Title 22 Code of California Regulations (CCR) sections, 51215, and the criteria for admission ser forth in Sections 5133, 51118, 51124, 51120, 51335.5, 51334, 51335.6 and referenced sections of 51003(e), Welfare and Institutions Code (W&I) section 14132.25, and the Medi-Cal Manual of Criteria.
3. **ICF/DD.** SFHP reviews ICF/DD admission requests utilizing the Regional Center determination from the Certification for Special Treatment Program Services form HS 231.

C. **Clinical Review and Authorization Durations (SNF and Subacute).**
1. A medical necessity review is conducted prior to all admissions. Post-Acute Nurses collaborate with the members' treatment team to assess the complexity and frequency of nursing care required. This includes verification of the Preadmission Screening and Resident Review (PASRR) process which ensures members have been preliminarily assessed for serious mental illness and/or intellectual/developmental disability or related conditions prior to admission.
2. Prior authorization placement requests for members who are transitioning from an acute care hospital are considered expedited and follow expedited turnaround times specified in CO-22 Authorization Requests Policy.
3. Pre-Authorizations
    a. Skilled Nursing Care: Pre-authorized length of stay varies based on individual member need. If skilled care is required beyond the month of admission plus one month, SFHP and its delegated groups authorize and cover. Members are not transitioned into SFHP Direct Network (SDN) unless criteria is met.

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

b. Custodial Care:
    a. Pre-LTC: SFHP and its delegated groups authorize and cover custodial care during the month of admission plus one month. The authorization duration may not exceed this timeframe.
    b. LTC: SFHP is responsible for admissions that meet criteria and exceed the month of admission and month after. Delegated groups notify SFHP of members requiring Custodial LTC and SFHP reassigns those members into the SDN. Initial Custodial LTC authorizations and reauthorizations in a SNF or subacute setting may be approved for up to twelve (12) months. ICF/DD authorizations or reauthorizations may be approved for up to twenty-four (24) months.

D. **Notification Timeframes**
1. SFHP is responsible for knowing, in a timely manner, when members have admitted, discharged, or transferred. Late notifications may result in a denial.
    a. **Admissions**: LTC facilities shall provide SFHP with notice of an admission within 5 business days of the member admitting to the facility.
    b. **Transfers** (e.g., to hospital, another LTC facility, community via leave of absence): LTC facilities shall provide SFHP with notice of a transfer immediately, and not to exceed 7 calendar days.
    c. **Discharge:** LTC facilities shall provide SFHP with notice of an anticipated discharge as soon as the plan is known. SFHP will assist with Transitional Care Services to ensure members have been successfully connected to all needed services and supports.

E. **Leave of Absence and Bed Hold Requirements**
1. SFHP ensures the provision of a leave of absence/bed hold that a SNF, Subacute, and ICF/DD provides. SFHP allows members to return to the same LTC facility where they previously resided under the leave of absence/bed hold policies.
2. Bed Hold (BH)
    a. When a member residing in a LTC facility is admitted to an acute care hospital and is expected to return to the LTC facility within 7 days of departure, members may exercise their BH right. The facility must hold a bed vacant when requested by the attending physician, unless the attending physician notifies the LTC facility that the member requires more than 7 days of hospital care.
    b. The BH is limited to a maximum of 7 days per hospitalization.
3. Leave of Absence (LOA)
    a. LOA are granted in accordance with the member's individual plan of care and for the following specific reasons:
        i. A visit with relatives or friends.
        ii. Participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons.
    b. LOA time periods are restricted as follows:

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

i. Developmentally disabled members: 73 days
ii. Members in a certified special treatment program for mentally disordered persons, or members in a mental health therapeutic and rehabilitative program approved and certified by a local mental health director: 30 days.
iii. All other members: 18 days
    a. Up to 12 additional days of leave per year may be approved when the request for additional days of leave is in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient.

4. General requirements for LOA and BH are as follows:
    a. The day of departure is counted as day one of the LOA/BH, and the day of return is counted as one day of LTC care.
    b. Facility will hold the bed vacant during LOA/BH.
    c. LOA or BH is ordered by a licensed physician.
        i. For ICF/DD LOA, a physician's signature is only required when the member is leaving to participate in a summer camp for the developmentally disabled.
    d. Member's return from LOA/BH must not be followed by discharge within 24 hours.
    e. LOA/BH must terminate on a member's date of death.
    f. Facility claim must identify the inclusive dates of leave.
5. SFHP requires SNF facilities to notify the member or the member's authorized representative, in writing, of the right to exercise the BH/LOA provision. To educate SNF facilities on LOA and BH requirements, SFHP Clinical Operations staff fax a provider memo outlining expectations to the facility staff each time a member is admitted. This is in addition to new provider trainings conducted by SFHP's Provider Network Operations department. See PR-03: New Provider Training.
6. SFHP authorizes admissions to a new facility when the original facility claims an exception under the bed hold regulations or fails to comply with the regulations.
7. **ICF/DD:** If a member does not wish to return to the same ICF/DD Home, SFHP will provide care coordination and transition support, including working with the assigned Regional Center. 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. SFHP will take the lead on discharge and transition planning if the Member chooses to transition to a different SFHP covered level of care. 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.

F. **Provider Required Documentation.** SFHP requires the following documents to process the authorization request from the facility if member is admitted:

Level of Care	Required Documentation

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

SNF and Subacute	a. A complete face sheet b. Clinical Documentation for medical necessity review, when applicable (e.g., H&P, MD progress notes, PT/OT/ST evaluations and therapy notes, nursing notes, wound care notes, labs, & orders) c. Pre-admission Screening and Resident Review (PASRR) d. Minimum Data Set (MDS) e. Medi-Cal Long Term Care Facility Admission and Discharge Notification (DHCS MC 171 form), when applicable f. Bed Hold / Leave of Absence Notices, when applicable
ICF/DD	a. Certification for Special Treatment Program Services form (HS 231) b. Medical Review/Prolonged Care Assessment – PCA (DHCS 6013) c. MCP ICF/DD Authorization Request form) d. Bed Hold / Leave of Absence Notices, when applicable

G. **Population Health Management.** SFHP ensures members enrolled in care management programs are provided with Basic Population Health Management (refer to PHM-01 Population Health Management). SFHP ensures Transitional Care Services (TCS) are provided to members transitioning to and from nursing facilities (refer to CARE-18 Transitional Care Services).

H. **Access to Specialty and Ancillary Services.** Members requiring care outside the SNF, ICF/DD, or Subacute provider's scope of practice have access to routine, unusual specialty, and ancillary care provider services (e.g., PT/OT/ST, dental, behavioral health, transportation services including NEMT & NMT, etc.) and may obtain standing referrals. This includes access for disabled members pursuant to the Americans with Disabilities Act of 1990. SDN members may access care anywhere within SFHP Network and office visits do not require prior authorization. Timely access standards apply. Refer to CO-19 Specialty Care and Standing Referrals, CO-22 Authorization Requirements, and QI-05: Monitoring Accessibility of Provider Services for additional information.

I. **Physician Administered Drugs (PADs).** SFHP is responsible for members' medications furnished by the SNF facility and billed on a medical or institutional claim or that are part of the bundled per diem rate. If medications are dispensed by a pharmacy, and billed on a pharmacy claim, then they are carved out and paid by Medi-Cal Rx.

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

J. **Coordination of Benefits.** If a member has other health coverage (OHC), such as Medicare or commercial insurance, SFHP does not process the authorization request unless the service is known to be an excluded benefit (e.g. Custodial Care and Bed Holds are Medicare excluded benefits). SFHP is the payer of last resort. If OHC information is not on record at SFHP, but is known or reported by a provider, Clinical Operations staff notify Member Eligibility Management (MEM) staff for investigation. See Other Health Coverage and Coordination of Benefits (MEM-01).

K. **Long-Term Services and Supports Liaison**. SFHP's LTSS liaison assists facilities in addressing claims and payment inquiries and assists with care transitions to best support members' needs. SFHP's LTSS Liaison can be reached directly at LTSSLiaison@sfhp.org.

MONITORING

A. SFHP utilizes a variety of methods to monitor and track service utilization to identify patterns of over- /underutilization. The Utilization Management Committee (UMC) is responsible for the monitoring of utilization data to identify potential services being over- or underutilized. If a service is identified, the UMC will conduct further discussions and analysis to identify opportunities for improvement.

B. SFHP Clinical Operations Department monitors turnaround times of internal processing for compliance with standards.

C. SFHP Clinical Operations Department performs inter-rater reliability audits at least annually for both physician and nurse reviewers.

D. The Utilization Management Committee (UMC) reviews Appeals, IMRs, and State Fair Hearings resulting in authorization decision made by SFHP or one of its delegated medical groups. The UMC recommends corrective action and/or identifies where the Clinical Operations Department can revise the authorization process, if necessary, to improve the member experience, to address any barriers, and ensure the utilization management criteria are consistent with current industry and evidence-based practices. The Quality Improvement and Health Equity Committee (QIHEC) reviews an Appeals Report (overturned and upheld appeals) every quarter to monitor the activity of medical appeals.

E. SFHP's Member Services and Health Services Programs Departments evaluate member grievances and member appeals, as well as SFHP's member and provider satisfaction survey responses, to identify patterns and trends.

F. The SFHP Chief Medical Officer (CMO), Medical Director, or physician designee identifies potential quality issues (PQI), including provider preventable conditions (PPCs), and follows the PQI process defined in QI-18 and the PPC process defined in QI-19.

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

G. Dashboards and other reports regarding SFHP's Clinical Operations Department's monitoring activities are reviewed by the Utilization Management Committee (UMC) and presented to QIHEC at least annually for evaluation and corrective actions as needed.

H. At least annually, the Compliance and Oversight Department conducts an audit of the Long-Term Care program. Audits may be more frequent if deficiencies are identified and require corrective action.

DEFINITIONS

Basic Population Health Management (Basic PHM): an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

Custodial Care: Custodial Care services are services and supplies furnished to a person mainly to help him or her with activities of daily life. These services are commonly for patients whose health is not expected to improve. Custodial care differs from skilled home health nursing care in that home health nursing is the provision of intermittent skilled professional services to a member in the home for the purpose of restoring and maintaining the Member's maximal level of function and health. Services are rendered in lieu of hospitalization, confinement in an extended care facility or going outside of the home for the service. Nursing services provided are not primarily for the comfort or convenience of the Member or custodial in nature.

Intermediate Care Facility: A facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or skilled nursing facility that meets State standards and has been certified by DHCS for participation in the Medi-Cal program.

Level of Care (LOC): The intensity of medical care provided by the physician or health care facility.

Lower Level of Care (LLOC) Facilities: Facilities encompassing Long-Term Care Facility, Intermediate Care Facility, Adult Sub-Acute, Pediatric Sub-Acute, Long-Term Acute Care and Skilled Nursing Facility.

Long-Term Care (LTC): Custodial care in a facility for longer than the month of admission plus one month.

Medi-Medi Member: A member who has Medicare as primary and Medi-Cal as secondary insurance benefits. The term is synonymous to or also known as "dual eligible."

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

Pediatric Sub-Acute Facility: An identifiable unit of a certified nursing facility licensed as a skilled nursing facility and meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by DHCS for such purpose. Pediatric sub-acute care is very intensive, licensed, skilled nursing care provided in Distinct-Part/Nursing Facilities Level B (FS/NF-B) in acute care hospitals, or in Free-Standing Nursing Facilities Level B (FD/NF-B) to patients under age 21 who have a fragile medical condition.

Skilled Nursing Facility: Any institution, place, building, or agency licensed as a skilled nursing facility by DHCS or is a distinct part of a hospital that meets State standards (distinct parts of hospitals do not need to be licensed as a skilled nursing facility) and has been certified by DHCS for participation in the Medi-Cal program.

Skilled Nursing Care: Services that must be performed by a registered nurse or licensed practical (vocational) nurse. Skilled nursing service is not custodial in nature; it is a service reasonable and necessary for the treatment of an illness or injury. These services may be occupational therapies, physical therapies, speech therapies, wound care therapies and medication management and should improve the member's health.

Sub-Acute Facility: An identifiable unit of a skilled nursing facility accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by DHCS for such purpose. Sub-acute care is care needed by a patient who does not require hospital acute care, 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 inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care.

AFFECTED DEPARTMENTS/PARTIES

Health Services – Care Management
Compliance & Regulatory Affairs – Delegation Oversight
Delegated Groups
Network Providers
Operations – Claims
Operations – Member Services
Operations – Member Eligibility Management
Operation – Provider Network Operations

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. CO-19 Specialty Care and Standing Referrals
2. CO-22: Authorization Requests
3. CO-57: UM Clinical Criteria
4. MEM-01: Other Health Coverage
5. QI-05: Monitoring Accessibility of Provider Services

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

6. GA-01: Clinical Member-Grievances
7. GA-03: Member Appeals
8. DO-02 Oversight of Delegates
9. PR-03: New Provider Training
10. CARE-04 Complex Care Management
11. CARE-13 Enhanced Care Management.
12. CARE-18: Transitional Care Services
13. PHM-01 Population Health Management
14. Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items

REVISION HISTORY

Effective Date:	5/8/2006
Revision Date(s):	2/6/2009, 01/30/2012, 7/24/2013, 4/1/2015, 8/6/2015, 7/16/2018, 7/26/2018, 9/17/2020, 11/15/2022, 02/16/2023, 05/10/2023, 11/1/2023, 1/12/2023, 01/18/2024, 9/26/2024, 10/17/24, 4/17/2025

REFERENCES

1. MMCD All Plan Letter 13-003: Coordination of Benefits: Medicare and Medi-Cal
2. 22 CCR §§51118, 51120, 51120.5, 51121, 51124, 51124.5, 51124.6, 51215.5, 51215.8, 51334, 51335, 51335.5, 51335.6, 51349, 51003(e), 51535 and 51535.1
3. FFS SNFABN and SNF Denial Letters – http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSSNFABNandSNFDenialLetters.html
4. DHCS/SFHP Contract Exhibit A, Attachment III Long-Term Care (LTC) Services
5. CalAIM Population Health Management Policy Guide (May 2024)
6. DHCS APL 24-009 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Member to Managed Care (supersedes APL 23-004)
7. DHCS APL 24-010 Subacute Care Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (supersedes APL 23-027)
8. DHCS APL 24-011 Intermediate Care Facilities Carve-In for Individual's with Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (supersedes APL 24-011)

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

APPENDIX

Included and Excluded Per Diem Services

Facility Type	Per diem rates **include**	Per diem rates **exclude**
SNF	Room and board, nursing and related care services, commonly used items of equipment, drugs, supplies and services used for the medical and nursing benefit of patients	Physician services, physical therapy, occupational therapy, speech therapy, audiology services, podiatry, laboratory, radiological, and radioisotope services, pharmaceutical services and prescribed drugs, rehabilitation outpatient services, prosthetic and orthotic appliances, medical supplies and DME (other than those commonly used items of equipment, supplies and services used for the medical and nursing benefit of patients), chronic hemodialysis, and other services outlined in 22 CCR, Sections 51123 (b) and (c), and 51511(c) and (d).

Subacute	- Oxygen and all equipment necessary for administration including:
	  o Positive pressure apparatus (e.g., biphasic positive airway pressure),
	  o Oxygen conserving devices (e.g., Oxymizer),
	  o Nebulizers (e.g., Pulmoaide),
	- Ventilators, including humidifiers, in-line condensers, and in-line temperature measuring devices, calibration and maintenance
	- Feeding pumps and equipment necessary for tube feedings (nasogastric or gastrotomy), including formula
	- Speech therapy and language and audiology services
	- Occupational therapy services
	- Physical therapy
		- Allied health services ordered by the attending physician, excluding respiratory therapy
		- Alternating pressure mattresses/pads with motor
		- Blood, plasma and substitutes
		- Dental services
		- Durable medical equipment (DME), including custom wheelchairs
		- Insulin
		- Intravenous trays, tubing and blood infusion sets
		- Laboratory services (except as specified)
		- Legend drugs
		- MacLaren or Pogon Buggy
		- Medical supplies as specified in the list established by DHCS
		- Nasal cannula
		- Osteogenesis stimulator device
		- Parts and labor for repairs of DME if originally separately

Docusign Envelope ID: DCE30DDB-7B0B-4BED-957B-E989E3D4BF76

	- Equipment and supplies necessary for the care of a tracheostomy, including tracheostomy speaking valves - Respiratory and inhalation therapy services administered by other than a physician - Technical components of laboratory, pathology, and radiology - Equipment and supplies for continuous intravenous therapy - Equipment and supplies necessary for debridement, packing and medicated irrigation with or without whirlpool treatment	payable or owned by the beneficiary - Physician services - Portable aspirator - Precontoured structures (VASCO-PASS, cut out foam) - Prescribed prosthetic and orthotic devices for exclusive use of patient - Reagent testing sets - Therapeutic air/fluid support systems/beds - Transportation - Traction equipment and accessories - Variable height beds - X-rays (except as specified)
ICF-DD	- Active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related - services per 42 CFR section 483.440 - Case conference review of member's developmental needs - Joint development of individual service plans - In-service training of direct care staff and follow-up to ensure proper implementation of individual service plan - Advising on the need for provision of various types of intervention or specialized equipment beyond the capabilities of the facility or staff - Administrative services - Health support, food and nutritional and pharmaceutical services - Social services - The provision of routine and emergency drugs and biologicals to its members. Drugs and biologicals may be obtained from community or contract pharmacists or the	- Allied health services ordered by the attending physician - Alternating pressure mattresses/pads with motor - Atmospheric oxygen concentrators and enrichers and accessories (except as - specified) - Blood, plasma, and substitutes - Dental services - Durable medical equipment, including wheelchairs designed for one person - Incontinence supplies for beneficiaries ages 5 or more whose developmental deficits are such that bowel and bladder control cannot be attained (for ICF-DD-H and - ICF-DD-N) - Insulin - Intermittent positive pressure breathing equipment - Intravenous trays, tubing and blood infusion sets - Laboratory services (except as specified) - Legend drugs - Liquid oxygen system

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	facility may maintain a licensed pharmacy - Services usually required by persons with developmental disabilities. However, - actual programs provided to members shall be based on the specific needs identified - through member assessments. - Examples include sensory motor development, self-help skills training, and behavioral intervention programs - Transportation services when necessary for round trips to attending physicians - Habilitation program which shall include recreation, education, and effective use of leisure time and socialization skills - Early and periodic screening and diagnosis and treatment (EPSDT) - Specific equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria	- MacLaren or Pogon Buggy - Medical supplies as specified in the list established by DHCS - 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 - Transportation for day and related transportation services67 - Variable height beds - X-rays (except as specified)