



Policy and Procedure No: UM 38.5		Revision No: 5	
Division: Care Management			
Department: Utilization Management			
Title: PHC-CA Subacute Care Facilities			
Effective Date: 1/1/2024			
Supersedes Policy No: UM 38.0, UM 38.1, UM 38.2, UM 38.3, UM 38.4			
Reviewed/Revised by: Michael O'Malley		Review/Revision Date: 12/15/2025	
Approving Committee: Utilization Management Committee		Date: 12/15/2025	
Executive Oversight Committee Date: 12/16/2025			

Purpose:

To describe how PHC California (the Health Plan) coordinates and provides coverage of services provided by subacute care facilities in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 24-010. Subacute care facility services include those provided by a licensed general acute care hospital with distinct-part skilled nursing beds, or by a freestanding certified nursing facility.

Policy:

1. The Health Plan considers the term "institutional long-term care services" to mean the same as set forth in the CalAIM Terms and Conditions and W&I Code section 141814.102(f), and includes, at a minimum, all of the following:
 - a. Skilled nursing facility (SNF) services. Please refer to PHC California Policy and Procedure UM 32, Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care.
 - b. Subacute facility services
 - c. Pediatric subacute facility services (not applicable to the Health Plan as the plan's contract with DHCS excludes enrollees under age 21)
 - d. Intermediate care facility services, including homes for developmentally disabled (ICF/DD). Please refer to PHC California Policy and Procedure UM 39, Intermediate Care Facilities for the Developmentally Disabled.
2. Health Plan enrollees who are admitted to a subacute care facility are to remain enrolled in the plan instead of being disenrolled to Regular Medi-Cal (fee-for-service).
3. As a voluntary enrollment plan, the Health Plan does not receive assignment of new enrollees resulting from the mandatory transition from fee-for-service (FFS) Medi-Cal to Medi-Cal managed care for institutional LTC patients. The requirements of DHCS APL 24-010 concerning transitioning Medi-Cal Members do not apply.
4. As the Health Plan does not enroll persons under the age of twenty-one (21), the requirements of DHCS APL 24-010 concerning pediatric subacute care services do not apply.
5. The Health Plan authorizes and covers medically necessary adult subacute care services provided in both freestanding and hospital-based facilities. The plan determines medical necessity consistent with definitions in 22 CCR 51124.5 and 51124.6, W&I 14132.25 and the Medi-Cal Manual of

Criteria.

6. The Health Plan expedites authorization requests for enrollees who are transitioning from an acute care hospital to a subacute care facility. The plan makes authorization decisions within seventy-two (72) hours after receiving needed information.
7. The Health Plan ensures that enrollees are placed in a health care facility that provides the level of care most appropriate to the enrollee's medical needs, and verifies that facilities are under contract for subacute care with DHCS' Subacute Contracting Unit (SCU) or are actively in the process of applying for a contract with DHCS' SCU.
8. In the event a PHC California enrollee resides in a facility that is subject to a California Department of Public Health (CDPH) de-certification or suspension, or a Medi-Cal subacute care facility contract termination, the Health Plan will ensure the enrollee has appropriate transition options and does not experience a disruption in care.
9. In the event a Medi-Cal-eligible individual who is already residing in a subacute care facility subsequently elects to voluntarily enroll in PHC California, the enrollee may request continuity of care to remain in the same facility.
10. The Health Plan is responsible for covering treatment authorization requests (TARs) for adult care services for services under the per diem rate. (Note: The Health Plan does not enroll individuals under the age of twenty-one (21); requirements for pediatric subacute care do not apply). To request authorization of subacute care, providers must use the plan's supplied Prior Authorization Form (see attachment A).
11. In the event a Medi-Cal-eligible individual with a treatment authorization request (TAR) previously approved by DHCS subsequently elects to voluntarily enroll in PHC California, the Health Plan will honor the DHCS-approved TAR.
 - a. The Health Plan will honor DHCS-approved TARs for a period of six months after enrollment in the Health Plan, or for the duration of the TAR approval, whichever is shorter.
 - b. The Health Plan will cover the service(s) under the DHCS-approved TAR without a request by the enrollee, authorized representative, or provider in accordance with the requirements in DHCS APL 23-022, or any superseding DHCS APL.
 - c. The Health Plan may approve subsequent reauthorizations for up to six months. Reauthorizations may be approved for one year for enrollees who have been identified or meet the criteria of "prolonged care." Prolonged care classification recognizes that the medical condition of selected enrollee requires a prolonged period of skilled nursing care.
12. Enrollees who transfer from a subacute care facility to a general acute care hospital, followed by a medically necessary return to a subacute care facility, may return to the same subacute care facility where they previously resided under the leave of absence (LOA)/bed hold policies in accordance with 22 CCR sections 72520, 51535 and 51535.1.
 - a. Bed must be held vacant during the entire hold period, for maximum of seven (7) days for each bed hold period. If notified in writing by attending physician the patient requires more than seven (7) days of hospitalization, the subacute care facility is not required to hold the bed.



- b. The Health Plan regularly reviews all denials of bed holds.
 - c. The Health Plan provides transition assistance and care coordination to a new subacute care facility when a facility claims an exception under the bed hold regulations or fails to comply with the regulations.
 - d. The Health Plan allows enrollees to return to the same subacute care facility and to the same bed, if available, or at minimum the next available room in the facility, regardless of the duration of the hospitalization, in accordance with 42 CFR 483.15(e).
13. The Health Plan covers medically necessary services to enrollees who reside in or are obtaining care in subacute care facilities, including:
- a. Routine and unusual specialty referral and access
 - b. Ancillary services such as therapy (physician, occupational, speech)
 - c. Covered dental services
 - d. Covered behavioral health care services
 - e. Standing referrals
 - f. Medically necessary services through out-of-network providers, including access for the completion of covered services by an out-of-network provider or terminated provider
14. The Health Plan must meet standards for timely provision of access for its enrollees residing in subacute care facilities, including:
- a. Appropriate clinical timeframes
 - b. Standards for timely specialty appointments
 - c. Shortening or expanding timeframes
 - d. Arranging timely appointments during a provider shortage
15. The Health Plan designates an LTSS Liaison who serves as the plan's point of contact with subacute care facilities. The Health Plan expeditiously notifies providers of changes to LTSS Liaison assignment to ensure coordination and services to members.

Procedure:

- 1. The Utilization Management Registered Nurse (UMRN), under the direction of the Medical Director and the National Director of Care Coordination, processes authorization requests related to subacute stays. The UMRN receives the subacute Authorization Request Form (Attachment A) from the inpatient facility and processes the authorization pursuant to PHC California Policy and Procedure UM 22 Authorization Referral Process. He or she, with the guidance of the Medical



Director, is responsible for verifying medical necessity of subacute care facility services.

2. The Authorization Coordinator communicates decisions to modify, delay or deny services of subacute care facilities (adverse determinations) to enrollees as described in PHC California Policy and Procedure UM 22 Authorization Referral Process.
3. The UMRN, with the guidance of the Medical Director, determines that an enrollee's condition meets minimum standards of medical necessity for adult subacute level of care:
 - a. Physician visits are required at least twice weekly during the first month and a minimum of at least once every week thereafter.
 - b. Twenty-four (24) hour access to services available in a general acute care hospital.
 - c. The need for special medical equipment and supplies such as ventilators are in addition to those listed in Title 22 CCR, Section 51511(b).
 - d. Twenty-four (24) hour nursing care by a registered nurse.
 - e. Enrollee must need one of the following:
 - i. Tracheostomy care with continuous mechanical ventilation for at least fifty (50) percent of the day
 - ii. Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the six (6) treatment procedures listed below
 - iii. Administration of any three of the six (6) treatment procedures listed below:
 1. Total parenteral nutrition (TPN).
 2. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five (5) days per week.
 3. Tube feeding (NG or gastrostomy).
 4. Inhalation therapy treatments during every shift and a minimum of four (4) times per twenty-four (24) hour period.
 5. Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or frequent IV drug administration via a peripheral and/or central line without continuous infusion such as via Heparin lock.
 6. Debridement, packing, and medicated irrigation with or without whirlpool treatment.
4. The UMRN confirms that subacute facilities where enrollees may be placed are on the [Medi-Cal provider list](#). If a requested facility is not on the list, the UMRN redirects placement to a facility that is on the list and has a bed available.



5. The UMRN receives subacute bed hold requests from subacute attending physicians and process them with guidance from the Medical Director pursuant to paragraph ten in this policy and procedure. The Medical Director is responsible to review bed hold requests that the UMRN denies that do not meet bed hold criteria as described in paragraph ten in this policy and procedure.
6. In the event a new enrollee resides in a subacute care facility at the time of enrollment, the UMRN notifies the enrollee or authorized representative of their right to request continuity of care and furnishes a copy of that notification to the facility. If the Health Plan denies continuity of care, the plan provides the enrollee with a written Notice of Action (NOA) of an adverse benefit determination in accordance with DHCS APL 21-011 and PHC California Policy & Procedure UM 22 and furnishes a copy of the NOA to the facility.
7. **The National Director of Care Coordination serves as the Long Term Services and Supports (LTSS) liaison. The role and responsibilities of the LTSS Liaison include, but are not limited to:**
 - a. Assisting facilities in addressing claims and payment inquiries
 - b. Assisting with care transitions among LTSS providers to support enrollees' needs
 - c. Disseminating contact information to the plan's providers
 - d. Knowing the appropriate internal plan resources to call on in order to serve as the single point of contact for providers
 - e. Receiving training on the full spectrum of rules and regulations pertaining to Medi-Cal covered LTC services, including:
 - i. Referral requirements and processes
 - ii. Authorization processes
 - iii. Payment and coverage policies
 - iv. Timely claims payment requirements
 - v. The provider dispute resolution process, and related policies and procedures
 - vi. Care management, coordination and care transition policies among the LTSS provider community to best support enrollee needs in relation to LTC services
8. The National Director of Care Coordination or designee orchestrates and provides Basic Population Health Management to enrollees residing in subacute care facilities, including Transitional Care Services, as described in PHC California Policy and Procedure CM 13 Population Health Management.
9. The Director of Member Services and Call Center Operations or designee provides transportation services, including NEMT and NMT, to enrollees who are receiving subacute care.
10. The National Director of Contracting and Provider Relations or designee offers a contract to subacute care facilities within the Health Plan's service area that have a subacute care contract

Commented [SJ1]: @Claudia Silva-Trigo Hi Claudia, I need another set of eyes on my revisions to this Procedure item #7 before resubmitting the policy to DHCS. Would you please review or forward to the right person? Need by 10/23/2025. Thank you! @Tiffany Jarrett

Commented [CS2R1]: Hi Sandy, I believe Tamarra would be the most appropriate person to advise on this. Since I generally am not involved in the PHC LTC Policies, I am not familiar enough to advise on policy revisions. I mainly work with the Medi-Cal Waiver Program. @Tamarra Dubuisson can you comment on this, please? I am happy to assist in any other way; however, I would need to do a deep dive on the current P&Ps for LTC admissions and discharges. Please let me know if this needs to be reassigned to me. Thank you.

Commented [SJ3R1]: @Tamarra Dubuisson



with DHCS' SCU or are actively in the process of applying for a Medi-Cal subacute care contract and are enrolled in Medi-Cal. He or she is responsible to develop sufficient network capacity to enable timely enrollee placement in subacute facilities within five business days of a request as outlined in W&I section 14197(d).

11. The Director of Member Services and Call Center Operations or designee and the National Director of Care Coordination or designee maintain grievance and appeal systems for enrollees residing in subacute facilities, as described in PHC California Policy and Procedure RM 7 Enrollee Grievance Process, and UM 24 Adverse Benefit Determination Appeal Process.

Definitions:

Subacute level of care means a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

Monitoring:

The Utilization Management, Quality Improvement and Health Equity, and Member and Provider Committees are responsible to review this policy and procedure annually and update it accordingly.

References:

1. [DHCS APL 23-027](#), Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, published September 26, 2023.
2. [DHCS APL 22-012 \(Revised\)](#), Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx, published December 30, 2022.
3. [DHCS 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, published August 15, 2023.
4. [DHCS APL 23-020 \(Revised\)](#), Requirements for Timely Payment of Claims, published October 12, 2023.
5. [DHCS APL 22-027](#), Cost Avoidance and Post-Payment Recovery for Other Health Coverage, published December 6, 2022.
6. [DHCS APL 13-003](#), Coordination of Benefits: Medicare and Medi-Cal, published February 8, 2013.
7. PHC California Policy and Procedure CL 3 Coordination of Benefits
8. PHC California Policy and Procedure UM 22 Authorization Referral Process
9. PHC California Policy and Procedure CM 13 Population Health Management
10. 22 CCR sections 51124.5, 51124.6, 51535, 51535.1, and 72520
11. 42 CFR 483.15(e)
12. W&I 14132.25, 14184.201(c)(2), and 14197(d).



13. [Medi-Cal Manual of Criteria](#)

14. [Subacute Contracting Unit \(SCU\) Medi-Cal Provider List](#)

Regulatory Agency Approval(s):

Date	Version	Agency/Purpose	Purpose	Response
	38.0	Department of Health Care Services (DHCS)	LTC Phase II, LTC5 AIR1	Pending
8/13/2024	38.1	DHCS	LTC Phase II, LTC 9	Approved
8/13/2024	38.1	DHCS	LTC Phase II, LTC 10	Approved
6/6/2024	38.1	DHCS	LTC Phase II, LTC 11	Approved
7/11/2024	38.3	DHCS	LTC Phase II, LTC 4	Approved
2/14/2025	38.4	DHCS	APL 24-010	Approved
11/18/2025	38.5	DHCS	2024 Operational Readiness MOR.0248	Approved



Attachment A



Prior Authorization Request Form



Instructions
 Prior authorization is required for all services listed in the tables below. Please submit the request via the portal at <https://positivehealthcare.net/california/for-providers-portals/>. **Inpatient** requests/notifications may also be faxed to (888) 238-7463 and **outpatient** requests may be faxed to 1-888-272-7656. To confirm authorization status, check the portal or call Utilization Management at (800) 474-1434. Patient eligibility should be verified at time of service (see below for additional information).
 Please note that routine visits with network specialists do not require prior authorization. Instead, please complete a Direct Referral Form and give to the member to take to their appointment. **Direct Referral Forms do not need to be sent to the Plan.** Direct Referral Forms are located at:
 PHP <https://positivehealthcare.net/california/for-providers-publications/>
 PHC California <https://positivehealthcare.net/wp-content/uploads/2022/06/Direct-Referral-Authorization-Form-PHC.pdf>
Eligibility Verification for PHP (HMO SNP) (Medicare Advantage Part D plan) & PHC California (Medi-Cal HMO plan)
 For eligibility verification, please utilize the portal at <https://positivehealthcare.net/california/for-providers-portals/> or call (800) 263-0067.

Specialty Services Requiring Prior Authorization	
PHP (MEDICARE) SERVICES <ul style="list-style-type: none"> • Chemotherapy, photo and radiation therapy • Dialysis (in service area) • Durable medical equipment (DME) • EMG, nerve conduction studies • Hearing aids • Home health care, including skilled nursing, rehab, and home infusion • Inpatient care (acute, subacute, SNF, and long-term) • Part B Drugs (Physician Office Administered), excluding immunizations • PET scans • Interventional radiology & nuclear medicine • Out-of-Network Services • Outpatient hospital services, surgery, and rehabilitation (incl. PT/OT/ST) • Orthotics and prosthetics • Wound care 	PHC (MEDI-CAL CALIFORNIA) SERVICES <ul style="list-style-type: none"> • Chemotherapy, photo and radiation therapy • Community Supports/Enhanced Care Management (ECM) • Dialysis (in service area) • Durable medical equipment (DME) • EMG, nerve conduction studies • Hearing aids • Home health care, including skilled nursing, rehab, and home infusion • Hospice Care • Imaging studies & nuclear medicine (excluding preventative, x-ray and ultrasounds or single/flat view studies) • Inpatient care (acute, subacute, SNF, and long-term) • Physician Administered Drugs (excluding immunizations) • PET scans • Interventional radiology • Out-of-Network Services • Outpatient hospital services, surgery, and rehabilitation (incl. PT/OT/ST) • Orthotics and prosthetics • Wound care

Date of Request: _____ Check if Urgent

Patient Information	
Patient Name _____	Select Plan Option: <input type="checkbox"/> PHP (Medicare) <input type="checkbox"/> PHC California (Medi-Cal)
Member ID Number _____	Birth Date _____
Primary Care Provider Name _____	Contact _____ Phone _____ Fax _____
Referring Provider Information	
Primary Care Provider Name _____	Contact _____ Phone _____ Fax _____
Indication for Referral	
Diagnosis(es)/Code(s) _____	CPT Code(s) _____
List Patient's Clinical Condition, Lab Data, or Other Diagnostic Data _____	
Requested Consultation or Service _____	
Requested (Refer to) Provider Information	
Requested Provider/Facility Name _____	Phone _____ Fax _____

Standard authorization requests are processed within 14 days. Valid expedited requests are processed within 72 hours.

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