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_______________________________________ Date _______________________________
Emily Duran
Chief Executive Officer

_______________________________________ Date _______________________________
Chief Medical Officer

_______________________________________ Date _______________________________
Chief Compliance and Fraud Prevention Officer

_______________________________________ Date _______________________________
Director of Utilization Management

_______________________________________ Date _______________________________
Director of Population Health Management

_______________________________________ Date _______________________________
Senior Director of Provider Network

I. PURPOSE

The Kern Health System, (KHS), Long Term Care Program serves to implement a comprehensive integrated process that actively evaluates and manages the utilization of health care services and resource delivery to members requiring long term care services (LTC). To this end KHS has established mechanisms for identification, authorization, and coordination, of these services through a designated KHS LTC team to support the LTC Program.

The Long-Term Care Program assures that:

1. The setting the service is delivered is consistent with the medical care needs of the member,

2. Service is delivered at the appropriate time,
3. Members receive appropriate quantity and quality of services,
4. Members have access to a comprehensive set of services based on their needs and preferences across the continuum of care including Basic Population Health Management, transitional care services (TCS), care management programs, and Community Supports.

II. POLICY

1. Kern Health Systems (KHS) shall authorize utilization of nursing facility services for members when medically necessary.

2. KHS ensures access to licensed long-term care facilities to members in need of long-term care services. These facilities include:
   A. Skilled Nursing Facilities,
   B. Sub-acute Facilities (pediatric and adult) effective date TBD by DHCS,
   C. Intermediate Care Facility for the Developmentally Disabled (effective date TBD by DHCS).

3. KHS members shall receive services that are medically necessary and consistent with their diagnoses and Level of Care (LOC) requirements. Authorization of these services considers the individual needs of the member such as comorbid conditions, behavioral health, and ADL management needs that might exist and the ability of the local health care delivery system to meet these members' needs.

4. KHS shall maintain standards for determining levels of care and authorizing services that are consistent with policies established by the federal Centers for Medicare and Medicaid Services (CMS) and in accordance with: a. 22 CCR § 51335 Title 22. Social Security Division 3. Health Care Services Subdivision 1. California Medical Assistance Program (Refs & Annos) Chapter 3. Health Care Services Article 4. Scope and Duration of Benefits § 51335. Skilled Nursing Facility Services.

5. KHS will utilize the California DHCS Provider Manual Part 2 LTC for benefit guidance in approving, coordinating, and reimbursing LTC services:
   https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=*_*l00*+OR+*_*z00*+OR+*_*z02*&wFLogo=Part2+%23+Long+Term+Care+(LTC)&wPath=N

6. KHS will utilize the following Medical Necessity Criteria for Skilled LTC:
   a. Medi-Cal Manual of Criteria R-15-98E Chapter 7.0 Titled " Criteria for Long Term Services at:
   https://www.dhcs.ca.gov/formsandpubs/publications/Documents/Medi-Cal_PDFs/Manual_of_Criteria.pdf

7. KHS will adhere to and provide Continuity of Care provisions for SNF members in compliance with APL 23-004 and APL 18-008.

III. DEFINITIONS

Skilled Nursing Facility (SNF)	A special facility or part of a hospital that provides medically necessary services provided by nurses, therapists, and/or physicians. A SNF is a licensed facility with the staff and equipment to provide nursing care and/or rehabilitative services at different levels as needed. The levels of care can vary, but usually include Subacute Care, Skilled Care and Long-Term Care.
Intermediate Care Facility (ICF)	A health facility that provides inpatient care to ambulatory or non-ambulatory patients that have a recurring need for skilled supervision and need supportive care.
Sub-acute Facility	Facilities with a level of care that is less intensive than acute care but is more intensive than skilled care.
Skilled Care	Services rendered by skilled nursing or rehabilitation staff that involves management, observation, and evaluation of the treatment plan. Care provided by a nurse, physical therapy, occupational therapy, and speech therapy are considered skilled services by Medicare definition. Any service that could be safely done by a non-medical person without the supervision of a nurse is not considered skilled care.
Skilled Nursing Care	The skilled nursing facility level of care is the level of care needed by Medi-Cal beneficiaries who do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care, but who require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses, or the equivalent thereof, as set forth in Section 51215. 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 parttime and intermittent.
Nursing Facility Level A (NF-A)	Known as the Intermediate Care Level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.
Nursing Facility Level B (NF-B)	Known as the Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse, yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care
Subacute Care	Sub-acute care is 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 most patients in a skilled nursing facility. Sub-acute patients are

	medically fragile and require special services, such as chronic ventilator management, inhalation therapy, tracheotomy care, parenteral nutrition, and complex wound management care.
Long Term Care	Long-Term Care, also known as extended care or custodial care, and is recommended for patients who require longer stays when their care needs are no longer able to be met at a lower level of care. Patients with a chronic disease or debilitating medical condition such as Alzheimer's, heart disease, or stroke may require ongoing long-term care to improve their quality of life. This type of care provides patients with 24-hour care designed to support individual medical needs and may include a combination of a customized diet, restorative exercise, and assistance with daily activities. Long Term Care is: The member has been reviewed, assessed, and determined that discharge potential is not possible, and placement is assumed for care in a facility for longer than the month of admission plus one month.
Short Term Skilled Care	Short-Term Care, also known as skilled nursing or post-acute rehabilitation, is provided for patients recovering from a surgery, illness, or other type of injury that is expected to improve over a short period of time. Typically, patients only spend about 25-30 days in a short-term care center with the intention of successfully transitioning from hospital to home with the tools necessary for each phase of recovery. Short-term care is tailored to each patient's individual rehabilitation needs and may involve a range of services including speech, physical or occupational therapy. The goal for this level of care is to provide patients with the rehabilitation care they need to be able to return home to their active and independent lifestyle.
Minimum Data Set (MDS)	The MDS is a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status. It is commonly used in long-term care facilities and outpatient and home-based social service programs for older adults.
Pre-Admission Screening and Resident Review (PASRR)	Federal law requires NFs to perform PASRR screens for mental illness, intellectual disability, and related conditions. There are procedures and information that are applicable to all situations requiring prior approval. Purpose of PASRR is as follows: A. To determine whether a resident requires a specific level of nursing care,

	B. To determine if there is suspicion of serious mental illness (MI) or intellectual disability/related condition (MI or ID/RC) C. To assess persons suspected of having serious MI or ID/RC, D. To assess whether specialized services for MI or ID/RC are needed; and, E. To prevent inappropriate placement in a NF by determining whether the resident is more appropriately served in a specialized program.
Plan Of Care	Individual written plan of care in each patient's medical record. Institutional providers such as Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) must include a written plan of care individual written plans are required by CFR Title 42 , Chapter IV , Subchapter G , Part 483 to be approved and signed by a physician. Plans should include: A. Diagnosis, symptoms, complaints, and complications, B. Description of individual's functional level, C. Objectives D. Orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures, E. Plans for continuing care, and F. Plans for discharge.
SNF MD Visits	Medi-Cal beneficiaries in the facility shall be visited by their attending physician no less often than once every 30 days for the first 90 days following admission. Subsequent to the 90th day, an alternative schedule of visits may be proposed, subject to approval (LTC Department MD). At no time, however, shall an alternative schedule of visits result in more than 60 days elapsing between physician visits.
Therapy Services	Facility Therapy Services: Federal Law states that "each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care." In many cases, however, these therapy services can and should be performed as part of the nursing facility inclusive services (covered under the facility's per diem rate) and, therefore, are not separately reimbursable.
Inclusive Items	Inclusive items are all supplies, drugs, equipment, and services necessary to provide a designated level of care. These items are included in the LTC rate unless listed as separately reimbursable in California Code of Regulations (CCR), Title 22. All incontinence supplies are included in the facility rate and are not separately

	reimbursable for LTC patients, except for Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H).
Personal Hygiene Items	The rates for Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) services include the cost for various personal hygiene items which facilities are required to furnish pursuant to federal law. Personal hygiene items include items such as denture cleaners, denture adhesives, dental floss, oral cleansing swabs, hair combs and brushes, lotions, shaving soap/cream, toothbrushes and toothpaste and tissue wipes for personal use. LTC providers cannot purchase items of personal hygiene with client funds.
Exclusive Items	Exclusive items are supplies, drugs, equipment or services not included in the per diem rate and are separately reimbursable subject to the utilization review controls and limitations of the Medi-Cal program outlined in LTC Part 2 Manual for Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items.
Share of Cost (SOC)	Share of Cost Clearance Transactions Long Term Care (LTC) facilities may be required to perform SOC clearance transactions when a recipient with an unmet SOC is admitted, or when a recipient's SOC exceeds the total charges of the Medi-Cal rate for a given month's stay. Non-Covered Medical Services Defined Requirements of Johnson v. Rank As a result of the Johnson v. Rank lawsuit, Medi-Cal recipients, not their providers, can elect to use their Share of Cost (SOC) funds to pay for necessary, non-covered, medical, or remedial-care services, supplies, equipment and drugs (medical services) that are prescribed by a physician and part of the "plan of care" authorized by the recipient's attending physician.
Bed Hold (BH)	Bed-Hold applies when a recipient residing in a nursing facility is admitted to an acute care hospital. A. The BH is limited to a maximum of seven days per hospitalization. B. The day of departure is counted as one day or LOA/BH, and the day of return is counted as one day of inpatient care.
Leave of Absence	A leave of absence (LOA) may be granted to a recipient in accordance with the recipient's individual plan of care and for the following reasons, A. A LOA is an overnight visit (or longer) to the home of relatives or friends, the time-period is restricted to Eighteen days per calendar year for non-developmentally disabled recipients. B. At least five days of LTC inpatient care must be provided between each approved LOA.

Other Health Coverage	Other Health Coverage (OHC) when a recipient has both Medicare fee-for-service and OHC, the provider must bill payers in the following order: A. Medicare for Medicare-covered services B. OHC carrier C. Medi-Cal. Attach the Medicare Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN) or Medicare Common Working File documentation and the OHC Explanation of Benefits (EOB) to the Medi-Cal claim

IV. CRITERIA

Skilled Nursing Criteria
To qualify for skilled nursing facility services, a patient shall have a medical condition which needs visits by a physician at least every 60 days and constantly available skilled nursing services. The following criteria together with the provisions of Section 51124, will assist in determining appropriate placement:

1. Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician,
2. Need for constantly available skilled nursing services. A patient may qualify for nursing home services if the patient has one or more of the following conditions:
   A. A condition which needs therapeutic procedures. A condition such as the following may weigh in favor of nursing home placement.
      a. Dressing of postsurgical wounds, decubiti, leg ulcers, etc. The severity of the lesions and the frequency of dressings will be determining factors in evaluating whether they require nursing home care.
      b. Tracheostomy care, nasal catheter maintenance.
      c. Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for nursing home placement.
      d. Gastrostomy feeding or other tube feeding.
      e. Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self-care, where such is feasible for the patient. Colostomy care alone should not be a reason for continuing nursing home placement.
      f. Bladder and bowel training for incontinent patients.

3. A condition which needs patient skilled nursing observation. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a nursing home dependent on the severity of the condition.
   A. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in a nursing home:
      a. Regular observation of blood pressure, pulse, and respiration is indicated by the diagnosis or medication and ordered by the attending physician.
      b. Regular observation of skin for conditions such as decubiti, edema, color, and turgor.
      c. Careful measurement of intake and output is indicated by the diagnosis or medication and ordered by the attending physician.

4. The patient needs medications which cannot be self-administered and requires skilled nursing services for administration of the medications.
    A. Nursing home placement may be necessary for reasons such as the following:
        a. Injections administered during more than one nursing shift.
            i. If this is the only reason for nursing home placement, consideration should be given to other therapeutic approaches, or the possibility of teaching the patient or a family member to give the injections.
        b. Medications prescribed on an as needed basis.
            i. This will depend on the nature of the drug and the condition being treated and frequency of need as documented.
            ii. Many medications are now self-administered on an PRN basis in residential care facilities.
        c. Use of restricted or dangerous drugs, if required more than during the daytime, requiring close nursing supervision.
        d. Use of new medications requiring close observation during initial stabilization for selected patients.
            i. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities.
5. A physical or mental functional limitation.
    A. Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of intermediate care facilities.
        a. Bedfast patients.
        b. Quadriplegics, or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in nursing homes.
        c. Patients who are unable to feed themselves.
6. Mental limitations.
    A. Persons with a primary diagnosis of mental illness (including mental retardation) when such patients are severely incapacitated by mental illness or mental retardation.
    B. The following criteria are used when considering the type of facility most suitable for the mentally ill and mentally retarded person where care is related to his mental condition.
        a. The severity of unpredictability of the patient's behavior or emotional state.
        b. The intensity of the care, treatment, services, or skilled observation that his condition requires and,
        c. The physical environment of the facility, its equipment, and the qualifications of staff and
        d. The impact of the patient on other patients under care in the facility.
    C. The general criteria identified above are not intended to be either all-inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission.
    D. Special program services for the mentally disordered (as defined in chapter 3, division 5, title 22) provided in skilled nursing facilities are covered when prior authorization has been granted for such services.
        a. Payment for these services will be made in accordance with Section 51511.1. (l) A need for a special services program for the mentally disordered is not sufficient justification for a beneficiary to be placed in a skilled nursing facility. All

beneficiaries admitted to skilled nursing facilities must meet the criteria found in paragraph (i) of this section.

E. The placement criteria established in Section 14091.21 of the Welfare and Institutions Code must be met except in either of the following circumstances:
   a. The beneficiary's physician and the discharge planner determine that the beneficiary requires short-term nursing facility care for postsurgical, rehabilitation, or therapy services which are curative rather than palliative in nature; or
   b. The beneficiary's attending physician certifies in the medical record that transfer to a freestanding nursing facility would cause specific physical or psychological harm to the beneficiary.

Subacute Level of Care Criteria

1. **Adult subacute care** is a level of care that is defined as comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process. 24-Hour Nursing Care Twenty-four-hour nursing care must be provided by an RN. A minimum of one RN must be on each shift and dedicated to the subacute unit.

   A. Eligibility Criteria to qualify for the subacute program; the patient must need one of the following:
      a. Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day, or
      b. Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the six treatment procedures listed below, or
      c. Administration of any three of the six treatment procedures listed below:
         i. Total parenteral nutrition
         ii. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week
         iii. Tube feeding (nasogastric or gastrostomy)
         iv. Inhalation therapy treatments every shift and a minimum of four times per 24-hour period
         v. I.V. therapy involving:
            i. the continuous administration of a therapeutic agent, or
            ii. the need for hydration, or
            iii. frequent intermittent I.V. drug administration via a peripheral and/or central line (for example, with Heparin lock)
         vi. Debridement, packing and medicated irrigation with or without whirlpool treatment.

2. **Pediatric subacute care** is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function. Pediatric subacute level of care refers to very intensive, licensed, skilled nursing care provided in Distinct-Part/Nursing Facilities Level B (DP/NF-B*) in acute care hospitals, or in Free-Standing Nursing Facilities Level B (FS/NF-B*) to patients who have a fragile medical condition.

   A. Pediatric Sub Acute Eligibility Criteria
      a. To qualify for the pediatric subacute program, the patient must need one of the following:

b. Tracheostomy care with dependence on mechanical ventilation for a minimum of six hours each day. Tracheostomy care requiring suctioning at least every six hours, room mist or oxygen as needed, and dependence on one of the four (i. thru v.) treatment procedures listed below.

B. Total parenteral nutrition or other intravenous nutritional support and one of the five (a thru e) treatment procedures listed below:

   a. Skilled nursing care in the administration of any three of the five (a thru e) treatment procedures listed below:

      i. Intermittent suctioning at least every eight hours and room air mist or oxygen as needed.
      ii. Continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous, pharmaceutical administration of more than one agent via a peripheral or central line, without continuous infusion,
      iii. Peritoneal dialysis treatments requiring at least four exchanges every 24 hours d. Tube feeding via nasogastric or gastrostomy tube,
      iv. Other medical technologies required continuously,
      v. In the opinion of the attending physician and the KHS UM licensed nurse require the services of a professional nurse.

Long Term Care Facility Requirements:

1. A Long-Term-Care (LTC) facility must be a licensed institution (other than a hospital) which meets the following requirements:
   A. Qualified as a provider of services under Medi-Cal and licensed with the California Department of Public Health (CHDP),
   B. Contracted with KHS, (exception will apply if KHS does not have in-network capacity,
      a. KHS will offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas
   C. The LTC provider will maintain on the premises all facilities necessary for medical care and treatment,
   D. LTC will provide such services under the supervision of physicians,
   E. LTC services will be given by or supervised by a registered nurse, AND
   F. The LTC facility will comply and maintain documentation of medical records on all patients in compliance with Medi-Cal requirements.

2. It is the responsibility of KHS to ensure LTC Providers in its service area are licensed by the California Department of Public Health (CDPH) as a qualified LTC provider and the provider is willing to enter a Network Provider Agreement / contract with KHS a on mutually agreeable terms as well as meeting KHS credentialing and quality standards. KHS will ensure the LTC provider remains licensed, certified, operating in good standing.

3. In accordance with APL 21-003, KHS shall notify DHCS within 60 calendar days of termination of a LTC Network Provider or immediately if the termination is a result of the LTC Network Provider having been decertified by CDPH.
   A. DHCS will attempt to resolve the contracting issue when appropriate.

4. If termination of a LTC Network Provider Agreement is for a cause related to Quality of Care or patient safety concerns, KHS may expedite termination of the LTC Network Provider Agreement and transfer Members to an alternate KHS LTC Provider in an expeditious manner.
   A. KHS will expedite notification to the DHCS must be notified of the termination within 72-hours of said termination. KHS will no longer assign or refer Members to the LTC Network Provider.

V. PROCEDURE:

1. The Primary Care Provider (PCP) and/or treating physician, in collaboration with hospital Discharge Planning (when transitioning from acute care) and KHS Utilization Management (UM) department staff, 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 most appropriate to the member's medical needs. These health care facilities include Skilled Nursing Facilities, Intermediate Care Facilities, Sub-Acute Facilities, and Pediatric Sub-Acute Facilities. 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).

2. MCPs must 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.

3. An authorization request for LTC services is required when the member meets any of the following criteria:
   A. Newly admitted to the facility.
   B. Medicare benefits are exhausted.
      a. Members with Medicare and Medi-Cal coverage become KHS financial responsibility when the member has exhausted his/her Medicare skilled days benefit.
      b. The LTC facility is required to submit the Medicare Denial Letter for non-coverage of services along with the KHS TAR request.
   C. Medicare or other healthcare coverage denies LTC, and the KHS UM Dept. licensed staff determine member meets Medi-Cal criteria for LTC.
   D. Member is 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."
   E. Returned to the LTC facility from an approved leave of absence beyond the approved return date.
   F. Member is newly eligible with KHS while residing in the LTC facility.
   G. Change in level of care (e.g., ICF level to SNF level).

4. To determine admission to an appropriate nursing facility, a case manager shall assess the member's health care needs and an estimate that the member will most likely require long term placement level of care.
   A. Considerations for placement:
      a. Self-determined directive of the member/care giver for the placement,

b. Geographical location of placement to maintain members in the community of their choice,
c. The unique medical and psychosocial needs of the member,
d. Exhaustion of community options/settings to safely maintain the member's health.

5. Upon the member's qualifying stay in the SNF and in consideration of applicable criteria for LTC placement to maintain the member's needs, an authorization TAR request is required. The TAR should be faxed or uploaded into the KHS Provider Portal and include the following:
   A. Face sheet
   B. Verification of KHS eligibility
      a. Providers may verify Medi-Cal eligibility through the KHS Provider Portal.
      b. Accessing the Medi-Cal Beneficiary Eligibility Verification System To verify member eligibility and health plan enrollment, providers must access the State of California's Medi-Cal Beneficiary Eligibility Verification System.
   C. Name of physician(s)
   D. State / KHS TAR treatment authorization request for LTC
   E. Preadmission screening resident review (PASARR)
   F. Durable Power of Attorney (DPOA) as applicable
   G. Medication list
   H. Specialty list
   I. Minimum DATA SET Assessment
   J. Current history and physical or physician's progress notes
   K. Medi-Cal Long-Term Care Facility Admission and Discharge Notification (MC 171)

6. Admission from Home to Long Term Care Facility
   A. A LTC facility is required to notify KHS before any elective admission.
   B. Prior authorization is required for all elective admissions from home.
   C. The following information must be submitted with the prior authorization request via TAR:
      a. Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in a long-term care facility and the physician's certification that placement in the long-term care facility is the appropriate level of care for the member.
      b. If placement follows an acute hospital stay within the past 30 calendar days hospital history and physical and discharge summary.
      c. If the member has not been confined in an acute care hospital within the past 30 calendar days, the Primary Care Provider's progress notes for the past six (6) months.

7. TAR determinations must be made timely, not to exceed regulatory turnaround timeframes for determination and notification of Members and Practitioners.
   A. Routine (Non-urgent) Pre-Service-All necessary information received at time of initial request. Within 5 working days of receipt of all information reasonably necessary to render a decision
   B. Expedited-Within 72 hours of receipt of the request
   C. Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services)
      a. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been

agreed upon by the treating provider that is appropriate for the medical needs of that patient. CA H&SC 1367.01 (h)(3).

D. Retrospective Post Service requests will be processed when supported with the following information:
   a. Completed new TAR form
   b. MC171 (Medi-Cal LTC Facility Admission and Discharge Form)
   c. Medicare Denial as applicable
   d. PASSR
   e. MDS
   f. MD and social service notes
   g. Medication history.

8. For non-business hours SNF-LTC placement requests, the on-call UM licensed Nursing staff may be contacted telephonically and or will review the e-fax line for evidence of urgent or expedited referral requests. This process in place for all non-business hours, to include weekends, and holidays, 24/7. Based on receipt of the LTC candidate's medical information and other applicable authorization rules when the request meets criteria, the on-call nurses have the ability to approve covered services. The on-call staff additionally have access to a KHS on-call MD during non-business hours to facilitate peer to peer discussions and make utilization management determinations in the event there is a question of not meeting criteria or requires the clinical judgement of a KHS MD.

9. Upon determination of meeting criteria for LTC services, an approval will be issued to the facility in accordance with the mandated timeliness requirements and in compliance with Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.

10. TAR Approvals for LTC will be for 6-month intervals. TAR Approvals for LTC in most cases will be for 6-month intervals however depending on the circumstances may be granted up to one year, (i.e., COC 12 months).

11. Extensions require re-authorization on a case-by-case basis. KHS will adhere to Title 22 criteria for admission and continuing care for LTC facilities.

12. The LTC facility is responsible for verifying the LTC resident's eligibility each month via the KHS portal or the automated eligibility verification system (AEVS) at (800) 456-2387. If the member is no longer eligible with KHS, the TAR authorization will no longer be valid from the time the member lost eligibility.

13. TAR Request Denials
   A. Cases determined to not meet LTC guidelines based on Title 22 Medi-Cal Guidelines and the information available at the time of review, are managed as follows:
   B. If the SNF Review Nurse has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.

C. The SNF Review Nurse contacts the attending physician to discuss concerns regarding patient's acuity, treatment plan or length of stay (LOS), or to obtain any additional pertinent information that might assist with the level of care determination.
D. Denials of medical necessity are determined only by the KHS UM Review Physician Designee.
E. UM staff ensures the member, provider, and facility are notified in writing of a denial for LTC, including the applicable appeal rights in compliance with Medi-Cal Title 22 and H&S Code applicable regulations.

14. In the event of a LTC denial based on the member not meeting admission or no longer meeting the Title 22 Medi-Cal guidelines used to determine the medical necessity for continued placement in a long-term care facility; for care that can be delivered at a lower acuity level, an alternative setting will be approved/ recommended such as:
    A. In lieu of providing nursing facility services, the KHS nurse will assist with referring and coordinating member access to alternate support systems and services such as:
        a. Home Health for nursing and social services,
        b. CBAS,
        c. Long-Term Supports and Services (LTSS), and
        d. Multipurpose Senior Services Program (MSSP)
        e. Community based Service provider agencies and wrap around services.

15. Changes in a Member's Condition and a discharge need, allows a Nursing Facility to modify its care of a member or discharge under the following circumstances:
    A. Member's death
    B. Exhausted 7-day bed-hold
    C. Converted to hospice care
    D. Change in eligibility to another health plan
    E. Discharged to home or transfer to another LTC facility.

16. Discharge from LTC documentation requirements
    A. Discharge summary should be sent to the member's PCP upon discharge.
    B. If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the discharge day is not payable.

17. The facility must notify KHS MC171 (Medi-Cal LTC Facility Admission and Discharge Form).

Other LTC Service Considerations and Requirements

1. Continuity of Care (COC)
   Attempts to maintain continuity of care will be facilitated in recognizing any treatment authorizations made by DHCS for nursing facility services that were in effect when the beneficiary enrolled into KHS. KHS will put forth best efforts to identify members' requiring continuity of care before the transition by identifying the Member's SNF 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.

A. The COC requirement is established under W&I Code §14186.3(c)(3). COC for Medi-Cal is for a period up to 12 months.
B. For Nursing Facilities with residents who are assigned to KHS, existing approved DHCS TARs will be honored for the initial authorization and used to create a KHS authorization, which is valid for six-month period (increments) from the date of enrollment up to 12 months.
C. Members will be allowed to stay in the same SNF under continuity of care only if all of the following applies:
    a. The facility is enrolled and licensed by CDPH,
    b. The facility is enrolled as a provider in Medi-Cal,
    c. The SNF and KHS agree to payment rates that meet state statutory requirements, and,
    d. The facility meets the DHCS and KHS applicable professional standards and has no disqualifying quality-of-care issues.
D. Following their initial 12-month automatic continuity of care period, Members may request an additional 12 months of continuity of care, following the process established by APL 22-032, Continuity of Care for Medi-Cal Beneficiaries Who Transition into Newly Enroll in Medi-Cal Managed Care form Medi-Cal FFS, and for Medi-Cal Members who Transition into a new MEC on or after January 1, 2023, or any superseding APL
E. Members residing in a SNF who newly enrolls in an MCP on or after July 1, 2023, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 22-032 or any superseding APL. MCPs must notify the Member or their authorized representative and furnish a copy of the notification to the SNF in which the Member resides, of the Member's right to request continuity of care, consistent with APL 22-032, or any superseding APL.
F. For any COC not granted members will be provided a written notice of action of an adverse benefit determination in accordance with APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates.

2. Provider COC the completion of covered services shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services from that provider or the completion of covered services shall apply for a newly covered member requesting COC from a non-participating provider in compliance with HSC § 1373.96.
    A. For further information regarding COC refer to LTC P&P 13 Titled "Long-Term Care Continuity of Care, KHS UM P&P 3.39 Titled "Continuity of Care by Terminated Providers", and KHS UM P&P 3.40 Titled "Continuity of Care for New Members".

3. Change in beneficiary's Condition or Discharge
   A nursing facility may modify its care of a beneficiary or discharge the beneficiary if the nursing facility determines that the following specified circumstances are present:
    A. The nursing facility is no longer capable of meeting the beneficiary's health care needs,
    A. The beneficiary's health has improved sufficiently so that he or she no longer needs nursing facility services, or
    B. The beneficiary poses a risk to the health or safety of individuals in the nursing facility.
        a. When these circumstances are present, KHS will arrange and coordinate a discharge of the beneficiary and continue to pay the nursing facility the

applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

4. Leave of Absence
   Pursuant to W&I Code §14186.1(c)(4), for nursing facility, MMPs shall include as a covered benefit any leave of absence or bed-hold that a nursing facility provides in accordance with the requirements of California Code of Regulations (CCR), Title 22, §72520 or California's Medicaid State Plan.
   A. LOA will be authorized for up to seventy-three (73) days per calendar year for Members with developmental disabilities and eighteen (18) days per calendar year for all other Members.
   B. Up to twelve (12) additional days of LOA may be approved per calendar year in increments of no more than two (2) consecutive days. The additional days of LOA must be in accordance with the Member's care plan and appropriate to the mental and physical well-being of the Member.
   C. A leave of absence may be prescribed by a PCP for a visit with relatives or friends and outpatient diagnostic or treatment services at an acute hospital.
   D. Twelve days of leave per year may also be approved for the physical and mental well-being of a member.
   E. A provision for the leave of absence including dates, intended destination and reason for the leave must be documented in the member's plan of care.
   F. The request for a leave of absence must be submitted on a TAR and marked "leave of absence" two weeks prior to the leave
   G. KHS will issue a response within five business days of receipt of a completed request.

5. Bed Hold
   A. In accordance with 22 CCR Section 72520(When a member is transferred to acute hospital) Nursing Facilities are required to hold a bed vacant when requested by the member or member's responsible party, unless notified that the member requires more than seven days of acute hospitalization a Bed hold requires the following:

      a. Doctor's order
      b. A new TAR is not required for bed hold. Maximum bed hold is 7 calendar days
      c. When member returns to facility on the 8th calendar day current TAR is still valid.
      d. If a member returns to a Long-Term Care facility after 8 calendar days, a new TAR and required attachments must be submitted.
      e. A physician's order for hospitalization and bed hold must be in place. The member must be in the facility at least 24 hours prior to start of the bed hold.
   B. If the LTC Nursing Facility is aware that the member requires greater than seven days of acute hospitalization, the facility is not required to hold the bed and cannot bill KHS for any remaining bed hold days.
   C. Bed hold payments will not be made when a member is discharged from the facility that is receiving payment for a bed hold within 24 hours from his or her return from an acute care hospital. Bed hold payment terminates on the member's day of death.
   D. KHS will ensure through training and monitoring that SNFs notify the Member or the Member's authorized representative in writing of the right to exercise the bed hold provision.
      a. SNF and its staff have appropriate training on the required clinical documentation to exercise these rights.

E. The KHS LTC team will provide transition assistance and care coordination of the member to a new SNF when a SNF claims an exception under the bed hold regulations or fails to comply with the regulations. This will occur during the inpatient concurrent review and discharge planning process.

6. Notification to Social Security Administration
   A. For KHS members with SSI, the LTC facility is required to submit the MC171 form to the SSA within two weeks of admission to the facility.
      a. A copy of the form must be sent to KHS. The form must be filled out completely and accurately.
      b. KHS' s Long Term Care (LTC) Nurses will confirm the receipt of the MC171 form for all LTC KHS members with SSI.
7. Share of Cost
   A. Share of Share of Cost Clearance Transactions Long Term Care (LTC) facilities may be required to perform SOC clearance transactions when a recipient with an unmet SOC is admitted, or when a recipient's SOC exceeds the total charges of the Medi-Cal rate for a given month's stay.
   B. Non-Covered Medical Services Defined Requirements of Johnson v. Rank As a result of the Johnson v. Rank lawsuit, Medi-Cal recipients, not their providers, can elect to use their Share of Cost (SOC) funds to pay for necessary, non-covered, medical, or remedial-care services, supplies, equipment and drugs (medical services) that are prescribed by a physician and part of the "plan of care" authorized by the recipient's attending physician.
   C. Cost Clearance Transactions Long Term Care (LTC) facilities may be required to perform SOC clearance transactions when a recipient with an unmet SOC is admitted, or when a recipient's SOC exceeds the total charges of the Medi-Cal rate for a given month's stay.

8. Medi-Cal Pharmacy Benefits
   A. Consistent with guidance in APL 22-012, Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx, or any superseding APL, the financial responsibility for prescription drugs is determined by the claim type on which they are billed. If certain drugs are dispensed by a pharmacy and billed on a pharmacy claim, they are carved out and paid by Medi-Cal Rx. If the drugs are provided by the SNF and billed on a medical or institutional claim, KHS is responsible.
9. Requests for DME
   A. For residents residing in a LTC facility, it is the responsibility of the facility and its staff to meet the patient's needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility A. components such as rollators, wheel walkers, commodes, etc.).
      a. Exceptions in congruence with DHCS APL-15-018 Criteria and Coverage of wheelchairs and applicable seating and positioning components will apply to those patients residing in a skilled nursing facility and meet the APL criteria.

10. Miscellaneous Inclusive and Exclusive Items
    A. Inclusive Items are included in the facility reimbursement rates.
    B. Exclusive items are supplies, drugs, equipment or services not included in the per diem rate and are separately reimbursable subject to the utilization review controls and limitations of the Medi-Cal program outlined in LTC Part 2 Manual for Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items. Exclusive Items are subject to utilization

management controls for benefit and medical necessity review. https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ratefacilmisc.pdf

11. Facility Therapy Services
    Federal Law states that "each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care." In many cases, however, these therapy services can and should be performed as part of the nursing facility inclusive services (covered under the facility's per diem rate) and, therefore, are not separately reimbursable.
    A. Therapy services provide to the recipient that are covered by the per diem rate include, but are not limited to:
        a. Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
        b. Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient Care to prevent formation and progression of decubiti, contractures and deformities, including:
        c. Changing position of bedfast and chair-fast recipients
        d. Encouraging and assisting in self-care and activities of daily living
        e. Maintaining proper body alignment and joint movement to prevent contractures and deformities.

12. Specialized Rehabilitative Services
    Specialized Rehabilitative Services shall require prior authorization and undergo medical application of criteria for necessity review. Providers must submit a Treatment Authorization Request (TAR) for therapy services exceeding the nursing facility inclusive services when it is determined that additional services must be rendered to attain or maintain the highest practicable plan of care.

13. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
    As part of Basic Population Health Management (BPHM), KHS must ensure members are engaged with their assigned Primary Care Providers, including arranging transportation.
    A. KHS must provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation to Members, including those residing in a SNF, in accordance with APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses, or any superseding APL.
    B. This includes providing NEMT services if the Member is being transferred from an emergency room or acute care hospital to a SNF, without prior authorization.
    C. For MCP covered services requiring recurring appointments, KHS must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months. The Member must have an approved Physician Certification Statement form authorizing NEMT by the Provider.

14. Reimbursement
    The reimbursement requirement does not apply to any other services provided to a Member receiving SNF services such as, but not limited to, services outlined in Title 22 CCR, sections 51123(b) and (c) and 51511(c) and (d), SNF services provided by an Out-of-Network Provider, or services that are not provided by a Network Provider of SNF services.

A. Such non-qualifying services are not subject to the terms of this state directed payment and are payable by MCPs in accordance with the terms negotiated between the Network MCP and the Provider.
B. The reimbursement requirement applies only to payments made directly for SNF services rendered, and does not apply to other types of payments, including, but not limited to, Provider incentive and pay-for-performance payments.

MCPs must coordinate benefits with OHC programs or entitlements as described elsewhere in this APL. For SNF services provided to Members who are dually eligible for Medi-Cal and Medicare, MCPs must pay the full deductible and coinsurance in accordance with APL 13-003, Coordination of Benefits: Medicare and Medi-Cal, or any superseding APL.

15. Other Health Coverage

In accordance with APL-13-003 for the Duals population, KHS is responsible for providing medically necessary Medi-Cal services that are not covered by Medicare and for reimbursement to Medicare providers when total Medicare costs, including deductibles and coinsurance, do not exceed the Medi-Cal allowable FFS reimbursement rates. KHS will coordinate benefits for members residing in LTC facility with OHC programs or entitlements. For SNF services provided to Members who are dually eligible for Medi-Cal and Medicare, KHS will pay the full deductible and coinsurance in accordance with APL 13-003, Coordination of Benefits. KHS will adhere to other health coverage (OHC) rules for billing Medi-Cal. The following principles must be followed when billing Medi-Cal after billing OHC:

A. Medi-Cal may be billed for the balance, including OHC copayments, OHC coinsurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any.
   a. Medi-Cal will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as payment in full.
   b. An EOB or denial letter from the OHC must accompany the Medi-Cal claim
   c. The amount, if any, paid by the OHC carrier for all items listed on the Medi-Cal claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any OHC payment. (Refer to claim form completion instructions in this manual for more information).
B. Medi-Cal approved HCPCS codes, CPT® codes and modifiers should be billed.
   a. HCPCS codes, CPT codes or modifiers where OHC paid, but which Medi-Cal does not recognize or allow will not be paid.
C. Services that normally require a Treatment Authorization Request (TAR), the related procedures must be followed. These determinations will be consistent with the TAR Overview section of the Part 1 provider manual for additional information.
D. Medical Supply Providers After submitting an initial claim that establishes proof that OHC does not cover that supply, medical supply providers may submit claims for that supply for the same recipient and OHC without proof of OHC denial for a period of one year from the date of the EOB or OHC denial letter. Providers billing for medical supplies may refer to the Medical Supplies section of the appropriate Part 2 manual for important OHC billing information.

16. Population Health Management

In congruence with the KHS PHM Program and case management and care coordination policies, KHS ensures Members, receiving LTC SNF services, will have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), complex case management, care management programs, and Community Supports. KHS assigns each LTC member to the LTC team. The KHS LTC team staff will ensure

discharge planning support and coordination for LTC members or rereferrals to ensure they are successfully connected to all needed services and supports The KHS LTC team is comprised of RNs, LVNs, Social Workers, and administrative coordinators.

A. Functions of the LTC Team Include:
   a. SNF admission coordination
   b. Medical Necessity and benefit reviews for SNF TAR requests in coordination with an MD physician reviewer as necessary
   c. Care coordination collaboration with SNF Case management team and social workers which include the coordination of medically necessary drugs or medications
   d. Review of SNF treatment plans and progress notes to include MDs.
   e. Participation in SNF members ICT as requested
   f. Coordinating SNF admission notifications to the KHS impatient management team
   g. KHS internal collaboration with ECM and CBS Team members.

17. Education and Training

Education and Training is geared towards multiple audiences to include:

A. The KHS LTC Staff are educated on LTC processes by:
   a. Providing access links to California Code of Regulations (CCR), Title 22 medical necessity guidelines and the Medi-Cal Provider Manual for LTC Part 2,
   b. Undergoing orientation to KHS policies and guidelines for LTC
   c. Review of the KHS Provider Training Manual for LTC, and
   d. Receiving ongoing UM management support for the day-to-day processes in authorizing and coordinating LTC services.

B. Provider Nursing Facility Education
   a. Via the KHS reference guide,
   b. Providing access to or a copy of KHS LTC P&Ps,
   c. KHS Provider Relations orientation,
   d. Facilitating direct access to KHS LTC team staff to assist with questions and inquiries.

C. KHS contracted Primary Care Physicians and Specialists
   a. Via the KHS reference guide,
   b. Providing access to or a copy of KHS LTC P&Ps,
   c. KHS Provider Relations orientation,
   d. Access to KHS LTC team staff to assist with questions and inquiries.

D. Acute Care Hospital Case Managers, Attending Physicians, Discharge Planners and Social Workers
   a. Via the KHS reference guide,
   b. Via communication with the KHS assigned nursing staff for concurrent review and discharge planning for acute care events,
   c. Providing access to or a copy of KHS LTC P&Ps,
   d. KHS Provider Relations Department staff,
   e. Access to KHS LTC team staff to assist with questions and inquiries.

18. Monitoring Over and Under Utilization of LTC Services and Quality of Care

A. Monitoring for over and underutilization of LTC services and quality of care is performed by the KHS Utilization Management Department in coordination with other KHS departments (Quality Management, Provider Relations, and Claims) through multiple avenues and approaches to include:
   a. UM program processes requests using a systematic, consistent application of utilization management criteria for LTC and Skilled Nursing Facility requests by:
   b. Performing preadmission screening and functions via TAR and medical record information reviews supported by:
      i. Application of benefit and medical necessity criteria in congruence with Medi-Cal & HSC 1367.01 requirements to determine and process requests for LTC as well as ensuring the member is appropriate for LTC placement.
         1. Alternate arrangements will be provided as appropriate for those that do not qualify.

B. Ensuring a PASRR is completed prior to a member's admission for those requiring behavioral health of Developmental supports.
C. Ensuring UM decisions utilized for decision-making are based solely on the clinical appropriateness of care and services and are unhindered by financial gains and in compliance with KHS UM Program and processes supporting requirements of HSC 1365.3,
D. Processing LTC referral requests
E. Only a physician can make a denial determination based on medical necessity,
F. Monitoring and applying access to care standards as regulated by DHCS and DMHC and consideration is given to:
   a. Geographical access,
   b. Timely access,
   c. Appropriate facilities, equipment, staffing resources, and technologies,
   d. Cultural needs.
G. Requiring prior authorization of specific LTC services not included in the per diem rate, to Ensure that members receive the appropriate quantity and quality of health care services.
H. UM monitoring of ongoing LTC to include:
   a. Notifications of member change in condition
   b. Discharge notifications
I. Ensuring propre certification and ongoing certification in good standing in congruence with CDPH and DHCS standards and notification provisions for LTC facility licensing.
J. Re-evaluating TAR extensions to ascertain the member meets criteria for continued placement.
K. Utilizing KHS designated LTC licensed nurses and social workers as appropriate to support LTC care management activities for members through the care continuum by performing review of care plans, MDS records, TAR requests, medical record reviews, and care coordination functions.
L. Monitoring LTC member institutional events to include, emergency department encounters, acute admissions, and readmission activities.
M. Monitoring LTC related claims for unusual occurrence and sentinel event reporting,
N. Monitoring grievance and complaint data for adverse trends related to LTC services.
O. The KHS Utilization Management and Quality Management Committees will be furnished with routine reports related to LTC activities.
   a. All over and under Utilization trends and quality issues will be addressed by actively participating committee MD and Behavioral Health members for decision making on appropriate actions and necessary interventions to address and remedy adverse trends and or incidents.
   b. The KHS Quality Management Program is structured in compliance with 28-CCR-1300.70 requirements and NCQA accreditation standards.

P. KHS will report sentinel events, unusual occurrences, critical incidents, and provider decertification's to the appropriate governmental authorities in compliance with California regulations.

REFERENCE:

Revised 2023-06: Policy received additional revisions per DHCS APL 23-004, approval received on 5/22/2023. Approval received on 5/22/2023. **Revised 2023-04:** Policy revised for DHCS APL 23-004; approval received on 5/22/2023. **Revised: 2022-12:** Policy developed for APL 22-018. Policy received additional updates on 12/27/2022 in response to LTC AIR 12. DHCS issued approval on 1/19/2023.

1. 22 CCR § 51335 Title 22. Social Security Division 3. Health Care Services Subdivision 1. California Medical Assistance Program (Refs & Annos) Chapter 3. Health Care Services Article 4. Scope and Duration of Benefits § 51335. Skilled Nursing Facility Services https://www.dhcs.ca.gov/services/medi-cal/Documents/22%20CCR%20Section%2051335.pdf
2. Welfare and Institutions Code Sections 10725, 14105, 14108, 14108.1, 14091.21 and 14124.5,
3. W&I Code §14186.3(c)(3)
4. Sections 14110 and 14132, Welfare and Institutions Code.
5. Medi-Cal Manual of Criteria for subacute care: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/subacutadu.pdf
6. CFR Title 42 , Chapter IV , Subchapter G , Part 483
7. Electronic Code of Federal Regulations (e-CFR), Title 42 - Public Health, CHAPTER IV - CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER G - STANDARDS AND CERTIFICATION, PART 483.24 REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES https://www.law.cornell.edu/cfr/text/42/483.24
8. Johnson Versus Rank 2 U.S.C. § 1983, Title XIX of the Social Security Act, and 42 C.F.R. § 435.832(c)
9. California Code of Regulations (CCR), Title 22, §72520 or California's Medicaid State Plan.
10. CCR 51535
11. DHCS APL15-018
12. DHCS APL 13-003
13. R-16-00 August 5, 2004 MANUAL OF CRITERIA FOR MEDI-CAL AUTHORIZATION https://www.dhcs.ca.gov/formsandpubs/publications/Documents/Medi-Cal_PDFs/Manual_of_Criteria.pdf
14. DHCS APL 21-003
15. California HSCs-1367.01, 1363.5
16. CCR Title 28 1300.70
17. DHCS APL 22-021
18. CA. HSC § 1373.96
19. HSC § 1345
20. KHS UM P&P 3.39 Titled "*Continuity of Care by Terminated Providers*",
21. KHS UM P&P 3.40 Titled *"Continuity of Care for New Members".*