ALAMEDA ALLIANCE FOR HEALTH
Subacute Services for Medi-Cal Members
Member Frequently Asked Questions (FAQs)

Overview

Starting Monday, January 1, 2024, Alameda Alliance for Health (Alliance) will cover subacute services for Medi-Cal members.

Q: What is the effective date of this change?

A: Monday, January 1, 2024.

Q: What are subacute services?

A: Adult subacute care is the level of care needed by a patient who does not require hospital acute care but requires more intensive licensed skilled nursing care than provided to most patients in a skilled nursing facility.

Pediatric subacute care is a level of care needed by a person under 21 years of age who uses medical technology to compensate for the loss of a vital bodily function. Subacute patients require special medical equipment, supplies, and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding, and complex wound management care.

Q: What services will I receive in the subacute facility?

A: The services provided in a nursing home can include:

- Bed and board (daily meals)
- Certain durable medical equipment (DME)
- Medicine prescribed by your doctor
- Nursing care
- Physical, speech, and occupational therapy
- Respiratory therapy
- X-ray and lab work when needed

Q: Who is eligible for a subacute level of care?

A: For the adult or pediatric subacute programs, you may qualify if you have a tracheostomy with mechanical ventilation or mist with room air/oxygen with suctioning as well as some other treatments.

Q: How can I find out if I am eligible to receive subacute services?

A: If you have any questions about subacute services, please call:

Alliance Member Services Department
Monday – Friday from 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

Q: How do I get approved for subacute services?

A: Your doctor will send a request to the Alliance. If you are eligible, the Alliance will approve the request and work with your care team to find a place for you in a subacute facility.

Q: How long will I be able to stay in the subacute facility?

A: When you are approved for a subacute facility, you will be informed when that approval ends. If you still need care in a subacute facility after that time, your doctor can ask for the time to be extended.

Q: What if I already live in a subacute facility but the facility is not in the Alliance network?

A: If you live in a subacute facility now, you can remain at your current nursing home for up to one (1) year, even if the facility is not in the Alliance network.

Q: Will I have to move to a new subacute facility after the one (1) year of continuity of care ends?

A: After one (1) year, you may request an additional 12 months of continuity of care to remain in your current subacute facility.

Q: What happens if I am less than 21 and living in a pediatric subacute facility? Will I need to transition to an adult facility or just continue to stay where I am?

A: Approval for pediatric subacute services stops when you turn 21. Planning to move to an adult facility should begin at least two (2) months before you turn 21. We will help you and your facility staff on the discharge or transfer.

Q: Am I allowed to leave the facility for a short period of time?

A: Your facility can request Leave of Absence days for the Alliance to approve. You are allowed to spend up to 18 days per calendar year outside of the subacute facility.

Q: If I go to the hospital, is the home going to give away my bed to someone else?

A: The Alliance pays your facility to hold your bed for you during a hospital stay or Nursing Home stay for a limited period of time.

Q: What happens if, during my stay, my condition improves and I no longer meet the requirements for the subacute level of care?

A: If during your stay you no longer meet the criteria, you may be allowed to stay longer so that you have time to get ready to return home or another setting safely.

Q: What if I disagree with a decision about my care?

A: You will receive a letter of the decision. This is called a Notice of Action (NOA) letter. You (or your doctor, nursing home, or an authorized representative) may appeal the decision.

Q: How do I submit an appeal?

A: You can file an appeal by phone, in writing, or online within 60 calendar days from the date of the NOA letter.

By phone: Please call us and have your Alliance member ID card ready:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

By mail: Please call the Alliance Member Services Department at the number above and ask to have a form sent to you. When you get the form, please fill it out. Be sure to include your name, Alliance member ID number, and the service you are appealing.

Mail the form to:

Alameda Alliance for Health
ATTN: Alliance Grievance and Appeals Department
1240 South Loop Road
Alameda, CA 94502

Your doctor's office will have appeal forms available.

Online: Visit the Alliance website at **www.alamedaalliance.org**

Q: How is a complaint or concern submitted?

A: You, or someone representing you, may file a complaint (grievance) by calling:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

Q: How long will it take before I get an answer to my complaint or appeal?

A: Complaints relating to your care are considered either urgent or routine.

- If it is urgent, you should get an answer within 72 hours.
- If it is routine, you should get an answer within 30 calendar days.
- Complaints related to administrative, contractual, or claims processing are not considered urgent and will be resolved within 30 calendar days from receipt of the request.

Q: Will I get a bill if the Alliance approves my stay in a subacute facility?

A: Alliance Medi-Cal members do not have to pay for covered services. You may get an Explanation of Benefits (EOB) or a statement from a provider. These are not bills.