Policy:	GG.1822
Title:	**Process for Transitioning CalOptima Health Members between Levels of Care**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	03/01/1999
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for transitioning CalOptima Health Members between Levels of Care (LOC), as well as into and out of Long-Term Care (LTC).

II. POLICY

A. Transfer from an acute care facility to a Long-Term Care (LTC) Facility

1. The discharge planning process from the acute setting shall include a review of the Member's ability to be discharged to a community setting with referrals to Home and Community-Based Services (HCBS) and other waiver programs prior to transferring to an LTC Facility.

2. The acute care facility shall be responsible for all discharge planning aspects of a Member's transfer to an LTC Facility.

3. CalOptima Health, or a Health Network, may assist in coordinating the discharge planning of a Member from an acute care facility to an LTC Facility.

4. The acute care facility shall collaborate with all appropriate Interdisciplinary Care Team (ICT) staff to facilitate the transfer of the Member.

5. The admitting LTC Facility shall coordinate the medical and ancillary services with CalOptima Health, the Member's Health Network, and other appropriate agencies such as the Regional Center of Orange County (RCOC), as appropriate.

6. CalOptima Health or the Member's Health Network shall be responsible for a Member's transportation from an acute care facility to an LTC Facility, in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

B. Transfer from an LTC Facility to an acute care facility

1. An LTC Facility shall be responsible for coordinating a planned, emergent, or urgent transfer of a Member to an acute care facility.

2. An LTC Facility shall collaborate with all appropriate ICT staff to facilitate either a planned, emergent, or urgent transfer of a Member from an LTC Facility to an acute care facility.

3. The LTC Facility shall submit a Bed Hold payment request to the CalOptima Health Claims Department with appropriate Bed Hold accommodation codes for LTC level of care and Bed Hold dates of service.

4. CalOptima Health or the Member's Health Network shall be responsible for a Member's transportation from an LTC facility to an acute care Facility, in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

5. Nursing facility may request a bed hold while a Member is in the acute setting. If a Member does not return before the bed hold expires, the Member will be discharged from LTC Facility in accordance with CalOptima Health Policy GG.1810: Bed Hold, Long-Term Care.

C. Transition from a Health Network to CalOptima Health's Long Term Care services upon termination of a Member's Skilled Nursing Facility (SNF) Covered Services for CalOptima Health Members with Medicare coverage:

1. A Health Network shall notify the SNF and the CalOptima Health LTSS Department upon issuing the Notice of Medicare Non-Coverage (NOMNC).

2. A Health Network shall submit a copy of the NOMNC, by facsimile, to the CalOptima Health LTSS Department upon issuing the notice, in accordance with CalOptima Health Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage. The CalOptima Health LTSS Department shall review the document during the LTC authorization review process.

3. The facility shall submit an LTC Authorization Request Form (ARF) to CalOptima Health's LTSS Department in accordance with CalOptima Health policy.

D. Transition of care from skilled short stay to LTC custodial care (CalOptima Health Medi-Cal Only Members Assigned to Health Networks) shall include:

1. MD order; and

2. LTC ARF submitted to CalOptima Health's LTSS Department, in accordance with CalOptima Health policy.

a. A denial letter from skilled short stay to LTC is not required.

E. An LTC Facility may modify a CalOptima Health Member's level of care or coordinate a Member's discharge from the LTC Facility, with appropriate physician signature approval, if the following specified circumstances are present:

1. The LTC Facility is no longer capable of meeting the Member's health care needs;

2. The Member's health has improved sufficiently, so that the Member no longer needs nursing facility services; or

3. The Member poses a risk to the health or safety of individuals in the facility.

F. When one (1) of the circumstances in Section II.E, above, presents itself, the LTC Facility shall arrange and coordinate with CalOptima Health or a Health Network to discharge the CalOptima Health Member to the appropriate setting, including to the community with referrals for Home and Community-Based Services (HCBS), as appropriate.

III. PROCEDURE

A. Transfer from an acute care facility to an LTC Facility

1. Upon determination by the acute care facility attending physician and the ICT that a Member meets the criteria for transfer to an LTC Facility, the attending physician shall write an order for transfer to an LTC Facility of the appropriate Level of Care.

2. The hospital discharge planner shall work with the Member, Member's family, CalOptima Health, the Member's Health Network, or RCOC, as appropriate, to find placement in a CalOptima Health-contracted LTC Facility.

3. The acute care facility shall collaborate with all appropriate ICT staff to facilitate the transfer including, but not limited to, a CalOptima Health representative, a Health Network representative, a Primary Care Practitioner (PCP), the attending physician, hospital discharge planner, ancillary service providers, and outside agencies (e.g., RCOC, Orange County Behavioral Health Services (OCBHS).

4. Upon identification of an accepting LTC Facility, the hospital discharge planner shall coordinate the transfer, including transportation and Ancillary Services, with the physician, Member, Member's family, facility, CalOptima Health, the Member's Health Network, RCOC, and OCBHS, as appropriate.

5. Upon a Member's admission to an LTC Facility, the LTC Facility shall notify the CalOptima Health LTSS Department of the admission within twenty-one (21) calendar days after admission, or twenty-one (21) calendar days after CalOptima Health becomes financially responsible for the Member's admission, whichever is later.

B. Planned transfer from an LTC Facility to an acute care facility

1. Upon determination by the LTC Facility that a Member requires a planned admission to an acute care facility, the Member's attending physician shall obtain authorization for the acute care admission from CalOptima Health, or the Member's Health Network, as appropriate.

2. The attending physician shall initiate the discharge planning orders and inter-facility transfer orders.

3. The LTC Facility shall coordinate the transfer, including transportation and ancillary services, with the physician, Member, Member's family, facility, CalOptima Health, the Member's Health Network, RCOC, and OCBHS, as appropriate.

4. The LTC Facility shall verify with the Member, the Member's Authorized Representative, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the LTC Facility shall hold the bed for the Member, in accordance with CalOptima Health Policy GG.1810: Bed Hold, Long-Term Care.

5. Upon admission to the acute care facility, the acute care facility shall notify CalOptima Health or the Member's Health Network of the admission, as appropriate.

C. Urgent or emergent transfer from an LTC Facility to an acute care facility

1. Upon an LTC Facility identification of a Member requiring emergent acute care admission, the LTC Facility shall call for 911 transport of the Member.

2. The LTC Facility shall notify the attending physician of the urgent transfer and the attending physician shall order the 911 transfer.

3. The LTC Facility shall verify with the Member, the Member's Authorized Representative, or RCOC, as appropriate, if a bed hold is requested. If a bed hold is requested, the LTC Facility shall hold the bed for the Member, in accordance with CalOptima Health Policy GG.1810: Bed Hold, Long-Term Care.

D. Transition from a Health Network skilled nursing short-term stay to Long-Term Care (LTC)

1. If a Member no longer meets Medical Necessity criteria, or exhausts his or her Medicare SNF Covered Services, the Member will remain in the facility under the CalOptima Health LTC Medi-Cal benefit. The Nursing Facility shall notify CalOptima Health LTSS Department by using the LTC Authorization Request Form (ARF), including Notice of Medicare Non-Coverage (NOMNC) letter if applicable and MD order from the Member's PCP or attending physician.

2. CalOptima Health shall review the authorization request and make a determination in accordance with CalOptima Health Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B).

E. Transition from an LTC Facility to a community setting

1. The LTC Facility shall notify CalOptima Health or a Health Network of the Member's capacity and preference for discharging to a community setting as soon as the information is available to provide sufficient time to safely plan and coordinate the transition.

2. CalOptima Health or a health network shall work with the LTC Facility to ensure that all Medically Necessary services are provided in a timely manner upon discharge, and the Member's transition to the most appropriate level of community-based care meets the Member's medical and social needs. The Member's medical needs, supports, and services throughout the transition and post-discharge period shall be coordinated and may include, but is not limited to:

a. Documentation of pre-admission, or baseline status;

b. Coordination with appropriate waiver and other specialized programs such as the California Community Transitions Project (CCT) or the Home and Community Based Alternative Waiver (HCBA) to support the Member during the transition and ensure adequacy of resources post-discharge;

c. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based LTSS programs;

d. Initial coordination of care, as appropriate with the member's caregiver, other agencies and healthcare personnel; and

e. Provision of information for making follow-up appointments.

3. The LTSS department staff shall make a referral to the Case Management department or a Health Network, as appropriate, when the member is discharged from the LTC Facility.

IV. ATTACHMENT(S)

A. CalOptima Health Long-Term Care (LTC) Authorization Request Form (ARF)

V. REFERENCE(S)

A. Californian Children Services and CalOptima Health Memorandum of Understanding
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Policy EE.1135: Long Term Care Facility and Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) Contracting
D. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency and Non-Medical
E. CalOptima Health Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B)
F. CalOptima Health Policy GG.1810: Bed Hold, Long-Term Care
G. CalOptima Health Policy MA.6023: Notice of Medicare Non-Coverage and Notice of a Detailed Explanation of Non-Coverage
H. CalOptima Health Utilization Management Plan
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements For Nursing Facility Services In Coordinated Care Initiative Counties For Beneficiaries Not Enrolled In Cal MediConnect.
J. Long-Term Care Facility Agreement
K. Regional Center of Orange County and CalOptima Health Memorandum of Understanding
L. Title 22, California Code of Regulations (CCR), §§ 51003(e), 51118, 51120, 51120.5, 51121, 51124.5, 51124.6, 51212, 51215, 51215.5, 51215.8, 51335, 51335.5, 51335.6, 51334, 76079, 76345 and 76853

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/26/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1999	GG.1822	Process for Transferring CalOptima Health Members between Acute Care Facilities to Long- Term Care Facilities	Medi-Cal
Revised	04/01/2007	GG.1822	Process for Transferring CalOptima Health Members between Acute Care Facilities to Long- Term Care Facilities	Medi-Cal
Revised	02/01/2016	GG.1822	Process for Transferring CalOptima Health Member between Acute Care Facilities to Long- Term Care	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1822	Process for Transferring CalOptima Health Members between Care Facilities	Medi-Cal OneCare Connect
Revised	11/01/2017	GG.1822	Process for Transferring CalOptima Health Members between Levels of Care	Medi-Cal OneCare Connect
Revised	12/05/2019	GG.1822	Process for Transferring CalOptima Health Members between Levels of Care	Medi-Cal OneCare Connect
Revised	09/03/2020	GG.1822	Process for Transferring CalOptima Health Members between Levels of Care	Medi-Cal OneCare Connect
Revised	07/01/2021	GG.1822	Process for Transitioning CalOptima Health Members between Levels of Care	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1822	Process for Transitioning CalOptima Health Members between Levels of Care	Medi-Cal
Revised	01/01/2024	GG.1822	Process for Transitioning CalOptima Health Members between Levels of Care	Medi-Cal OneCare
Revised	10/01/2024	GG.1822	Process for Transitioning CalOptima Health Members between Levels of Care	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Authorized Representative	Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. OneCare: An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process and does not provide broad legal authority to make another individual's healthcare decisions.
Community Based Adult Services (CBAS)	Skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184,

Term	Definition
	51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005;

Term	Definition
	14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Home and Community-Based Services (HCBS)	Home and Community-Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Level of Care (LOC)	Criteria for determining admission to a LTC Facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima Health policies.
Long-Term Care (LTC)	For purposes of this policy, care provided for Members in a Skilled Nursing Facility and subacute care services.
Long-Term Care Facility	For the purposes of this policy, includes a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute facility] and Nursing Facility Level B (NF-B) [Skilled Nursing Facility (SNF)].
Long-Term Services and Supports (LTSS)	Medi-Cal: Services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting, and includes both LTC and Home and Community Based Services, and carved-in and carved-out services. OneCare: A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled Nursing Facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).

Term	Definition
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Medicare Non-Coverage (NOMNC)	A document that informs Members when their Medicare covered service(s) is ending and how to request an expedited determination from their Quality Improvement Organization (QIO).
Nursing Facility Level A (NF-A)	Known as the Immediate 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.
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).
Primary Care Practitioner/Physician (PCP)	Medi-Cal: A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

Term	Definition
	OneCare: A Practitioner/physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model Program, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Chile Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Skilled Nursing Facility (SNF)	Medi-Cal: Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program. OneCare: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.