

POLICY AND PROCEDURE	
Policy # and TITLE: UM82 Long Term care	
Primary Policy owner: Utilization Management	POLICY #: UM82
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) <input type="checkbox"/> All Departments 2) <input checked="" type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input checked="" type="checkbox"/> Benefits Administration (BA) 4) <input checked="" type="checkbox"/> Case Management (CM) 5) <input checked="" type="checkbox"/> Claims (CLMS) 6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input checked="" type="checkbox"/> Configuration (CFG) 9) <input checked="" type="checkbox"/> Provider Contracting (CONT) 10) <input type="checkbox"/> Cultural & Linguistics (CL) 11) <input type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input type="checkbox"/> Information Technology / Core Systems (IT) 16) <input type="checkbox"/> Pharmacy (PH) 17) <input checked="" type="checkbox"/> Provider Networks (PRO) 18) <input checked="" type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input checked="" type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input type="checkbox"/> Medical Management (MM)
PRODUCT TYPE: <input checked="" type="checkbox"/> Medi-Cal	Supersedes Policy Number: N/A

I. PURPOSE

To outline Health Plan of San Joaquin and Mountain Valley Health Plan (“Health Plan”)’s responsibility to authorize and provide medically necessary services provided in skilled nursing facilities (SNFs) to our Members.

II. POLICY

- A. Health Plan is responsible to authorize and cover medically necessary services provided in SNFs (both freestanding and hospital-based facilities), which includes:
1. Facility services,
 2. Professional services,
 3. Ancillary services, and
 4. Care coordination for both carved-in and carved-out Medi-Cal services.
- B. Health Plan is responsible for coordinating care for and ensuring members in need of Long-Term Care (LTC) are placed in a health care facility that provides the most appropriate level of care for the member's medical needs.
1. Members shall no longer be disenrolled from Health Plan to Medi-Cal FFS following admission into a SNF.
- C. Health Plan is responsible for coordination of benefits with other health coverage (OHC) programs, recognizing OHC as primary, and Medi-Cal as the payer of last resort, in accordance with Health Plan Policy CLMS15 Cost Avoidance and Post-Payment Recovery for Other Health Coverage.
- D. Health Plan is responsible for ensuring that SNF staff have training on benefits coordination, as described in Health Plan Policy PRO20 Provider Training and Education.
- E. Pharmacy services billed as a medical and/or institutional claim shall be reviewed in accordance with Health Plan Policies PH05 Prior Authorization Review and PH23 Submission of Pharmacy Benefit Prior Authorization & Claims.
- F. Health Plan is responsible for providing Population Health Management (PHM) services to Members residing in LTC in accordance with Health Plan Policies CM66 Case Management Programs, CM73 Enhanced Care Management, PHM01 Population Health Management, UM50 Community Supports, UM88 Transitional Care Services including:

1. Coordination of medically necessary drugs or medications on behalf of the Member,
 2. Basic Population Health Management
 3. Care Management Programs, and
 4. Community Supports.
- G. Health Plan provides 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, and Health Plan Policies UM 55: Emergency Transportation, Non-Emergency Medical Transportation and Related Expenses, and CS21 Non-Medical Transportation.
1. 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.
 2. For covered services requiring recurring appointments, Health Plan provides authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months.
 - a. The Member must have an approved Physician Certification Statement form authorizing NEMT by the Provider.
- H. Health Plan allows the Member to return to the same SNF where they previously resided when an acute hospital admission interrupts their SNF stay, in accordance with Medi-Cal leave of absence/bed hold policies.
1. Health Plan ensures that SNFs notify the Member and/or the Member's authorized representative in writing of their right to exercise the bed hold provision.
 2. Health Plan regularly reviews all bed hold denials.
 3. Health Plan ensures that the SNF staff are appropriately trained on leave of absence and bed hold requirements.

4. If a SNF claims an exception from the bed hold regulations, or fails to comply with the requirements, Health Plan provides transition assistance and care coordination to ensure the Member is placed in a new SNF.
- I. A Member residing in a SNF and newly enrolling in Health Plan may request continuity of care in accordance with Health Plan Policy CM69 Continuity of Care.
- J. Health Plan identifies an individual, or set of individuals, to serve as a liaison for the long-term Services and Supports (LTSS) Provider community.
 1. This role must serve as a single point of contact for the service providers in both a Provider representative role and to support care transitions as needed. This role shall have access to subject matter experts for issues related to:
 - a. Care transitions to best support the Member's needs, and
 - b. Assist providers in addressing claims and payment inquiries.
 - c. Health Plan ensures that their contact information is provided to Network Providers and notify them of any changes in the liaison's assignment as expeditiously in order to ensure coordination of services offered to Members.
 2. Liaisons receive training on the full spectrum of rules and regulations pertaining to the services they are coordinating, including referral requirements and processes, care management and authorization processes
 3. The LTSS liaison is trained in:
 - a. The rules and regulations pertaining to Medi-Cal covered LTC services, including payment and coverage policies
 - b. Timely claims payment requirements
 - c. The provider dispute resolutions process, and related policies and procedures

- d. Care management, coordination and care transition policies among the LTSS Provider community to best support Members' needs in relation to LTC services
 - e. Assisting facilities in addressing claims and payment inquiries
 - f. Disseminating their contract information to the plan's providers
 - g. Providers of changes to LTSS liaison assignment expeditiously to ensure coordination and services to members
 - h. Knowing the most appropriate internal plan resources to call on so the liaison can serve as the single point of contact for providers
4. UM provides policies and procedures training in:
- a. Authorizations and referrals
 - b. Care management
 - c. Care coordination
 - d. Care transitions

III. PROCEDURE

Health Plan Members New to LTC

- A. Facility requests for authorization for SNF services must be submitted to Health Plan via Health Plan provider portal at <https://www.hpsj.com/providers> or by sending the authorization request form by facsimile to the (209) 762-4702.
- 1. The authorization form must be filled out completely, including:
 - a. The Member's complete information, including name, health plan ID, address, date of birth and admission date if known,
 - b. The servicing provider that the service is to be authorized to, including specialty, address, and phone number,

- c. The ICD diagnosis for the treatment requested, and
 - d. The CPT/Procedure code and quantity being requested.
 - e. Clinical documentation to support the need for the requested service(s).
 2. If the clinical information is either inadequate or not submitted validating the need for LTC, Health Plan LTC staff reaches out and requests clinical information necessary to process the request.
- B. The authorization is processed in accordance with Health Plan Policy UM 01: Authorization and Referral Process.
 1. The LTC nurse shall work with the Case Manager (CM) in the acute care setting to ensure transfer of medical records to LTC facility, assuring that care is not interrupted, and continued provision of all medical necessary covered services to the Member enrolled with Health Plan.
 - a. Health Plan LTC staff authorizes prior authorization requests for Members transitioning from an acute care hospital in an expedited manner, requiring a response time of 72 hours, including weekends in accordance with Health Plan Policy UM 01: Authorization and Referral Process.
 2. The requestor shall include a copy of the completed Pre-admission Screening and Resident Review (PASRR) with the SNF authorization request.
 - a. The PASRR is required documentation prior to authorization of LTC services.
 - b. The PASRR is to be completed prior to placement in the SNF.
 3. All adverse determinations shall be completed in accordance with Health Plan Policy UM 07: Notification to Members of Denial, Deferral, Modification, and Terminate Actions.
- C. Health Plan's LTC staff shall collaborate with nursing facility staff to ensure the Member's:
 1. LTC needs are met,

2. Targeted healthcare outcomes are achieved, and
 3. Transitions between settings are effectively coordinated.
- D. Transfer of a Member from the SNF to an acute hospital must be communicated to Health Plan's LTC staff, and include:
1. A bed hold request for no more than seven calendar days per episode.
 - a. The LTC facility is responsible to ensure that a Member/ Member's authorized representative is informed regarding the right to exercise the bed hold provision.
 2. Health Plan's LTC staff shall coordinate discharge planning with the acute care facility to ensure the appropriate level of post-acute care and return to the originating LTC facility if the discharge occurs within seven calendar days.
 3. If the Member is not discharged from the acute care facility within seven days , the LTC staff shall coordinate discharge planning for the Member back to the previous SNF or to a new SNF that shall meet the Member's care needs.
 4. If the LTC SNF claims an exception under the bed hold regulations or fails to comply with regulations regarding bed holds, Health Plan LTC staff shall provide transition assistance and care coordination to the new LTC facility.
- E. A Member residing in an LTC may request a leave of absence from the LTC facility for personal reasons, such as visiting family or friends.
1. The Member is entitled to 18 days per calendar year and may extend an additional 12.

Member Transitions

- A. Health Plan ensures care transitions from one level of care to another do not delay or interrupt any medically necessary services or care for the Members transitioning to a nursing facility.
- B. Health Plan, ECM or CCM Care Manager provides the following traditional care services (TCS) during all transitions:

1. Coordinate with facility discharge planner, care or case managers, or social workers to provide case management and TCS.
2. Assist Members being discharged, or Member's parents, legal guardians, or authorized representatives by:
 - a. Evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and
 - b. Referrals and coordination with In Home Support Services (IHSS), Community Supports (CSS), Long Term Support Services (LTSS), and other Home and Community-Based Services (HCBS).
3. Maintain contractual requirements for Skilled Nursing Facilities to:
 - a. Share Minimum Data Set (MDS) Section Q, and
 - b. Health Plan's appropriate systems to import and store MDS Section Q data, and
 - c. Incorporate MDS Section Q data into transition assessments.
4. Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge.
5. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met.
6. Follow up with Members, Members' parents, legal guardians, or authorized representatives, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services in accordance with Policy UM 88: Transitional Care Services.

IV. ATTACHMENT(S)

- A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
- B. [Glossary of Terms Link](#)

C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

- A. DHCS All Plan Letter APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses
- B. DHCS All Plan Letter (APL) 23-004: Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care.
- C. DHCS contract Attachment III Section 4.3.11.C Transitional Care Services
- D. Health Plan Policy CLMS15 Cost Avoidance and Post-Payment Recovery for Other Health Coverage
- E. Health Plan Policy UM 01: Authorization and Referral Process.
- F. Health Plan policy UM 06: Medical Review Criteria.
- G. Health Plan Policy UM 07: Notification to Members of Denial, Deferral, and Modification Actions
- H. Health Plan Policy UM50 Community Supports
- I. Health Plan Policy UM 55: Emergency Transportation, Non-Emergency Medical Transportation and Related Expenses
- J. Health Plan Policy UM 88: Transitional Care Services
- K. Health Plan Policy CM66: Case Management Programs
- L. Health Plan policy CM 69: Continuity of Care
- M. Health Plan Policy CM73: Enhanced Care Management
- N. Health Plan Policy CS21: Non-Medical Transportation
- O. Health Plan Policy PH05 Prior Authorization Review
- P. Health Plan Policy PH23 Submission of Pharmacy Benefit Prior Authorization & Claims.
- Q. Health Plan Policy PHM01: Population Health Management
- R. Health Plan Policy PRO20 Provider Training and Education.

VI. REVISION HISTORY

**Version 001 as of 01/01/2023*

Version*	Revision Summary	Date
000	11/17, 1/21, 11/22, 5/23, 7/23	N/A

001	Moved policy to new template and updated to include having a liaison for the long-term Services and Supports (LTSS) Provider community	03/14/2024
002	Updated reference policies, revised LTSS Liaison information, revised bed hold days, removed 90 day transition period verbiage, grammar changes	03/25/2025
003	Updated LTSS liaison information and removed automatic CoC section, updated to address DHCS MOR.0248	10/14/2025
Initial Effective Date: 11/1/2017		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	003	12/02/2025
<ul style="list-style-type: none"> Privacy & Security Oversight Committee (PSOC) 		
<ul style="list-style-type: none"> Program Integrity Committee 		
<ul style="list-style-type: none"> Audits & Oversight Committee 		
<ul style="list-style-type: none"> Policy Review 	001	03/20/2024
Quality Improvement Health Equity Committee (QIHEC)		
<ul style="list-style-type: none"> Quality Operations Committee 		
<ul style="list-style-type: none"> Grievance 		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
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Department of Healthcare services (DHCS)	DHCS Contract Manager	003	11/04/2025
Department of Managed Care (DMHC)			

IX. Approval signature*

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, shall not be on the published copy