

# CONTRA COSTA HEALTH PLAN

## Utilization Management

### Title: Long Term Care

### Policy #: UM15.071

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#### Applies to:

- |  |                                   |     |
|--|-----------------------------------|-----|
| <input checked="" type="checkbox"/> Medi-Cal | <input type="checkbox"/> Medicare | All |
| <input type="checkbox"/> Commercial          | <input type="checkbox"/> N/A      |     |

#### Regulatory/Accreditation:

- |   |                                |                              |
|---|--------------------------------|------------------------------|
| <input type="checkbox"/> DMHC:                  | <input type="checkbox"/> CMS:  | x DHCS:                      |
| <input type="checkbox"/> Other Reg. References: | <input type="checkbox"/> NCQA: | <input type="checkbox"/> N/A |

#### Units:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Administration    | <input type="checkbox"/> Advice Nurses      | <input type="checkbox"/> All Staff                        |
| <input type="checkbox"/> Business Services | <input type="checkbox"/> Case Management    | <input type="checkbox"/> Health Ed/Cultural Ling.         |
| <input type="checkbox"/> Marketing         | <input type="checkbox"/> Member Services    | <input type="checkbox"/> Planning, Reg Affairs            |
| <input type="checkbox"/> Provider Affairs  | <input type="checkbox"/> Quality Management | <input checked="" type="checkbox"/> Auth/Utilization Mgmt |

## POLICY

Long Term Care (LTC) services are a covered benefit when a member needs to obtain medically necessary covered services. Contra Costa Health Plan conducts initial and concurrent admission reviews for non-delegated facilities to ensure the care and service(s) rendered or being rendered to its members are appropriate, without delay, and medically necessary. Admission reviews are equally important to identify potential discharge concerns and initiate care coordination in a timely manner. Lastly, concurrent review allows for the identification of provider preventable conditions (PPC- required for Medi-Cal members), potentially avoidable admissions (PAA), all-cause readmissions (ACR), potentially preventable readmissions (PPR), and never events.

## PURPOSE

The purpose of this policy is to ensure members receive quality care with continuity and coordination of care and appropriate utilization of services related to Long Term Care. This includes services available at Skilled Nursing Facilities (SNF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes, and Subacute Care facilities pursuant to the regulations set forth in APLs 24-009, 24-011, and 24-010. Effective January 1, 2023, DHCS required non-dual and dual LTC members (including those with a Share of Cost) receiving SNF services to be enrolled in an MCP. Effective January 1, 2024, institutional LTC members receiving services in a Subacute Care Facility or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) are required to be enrolled in an MCP.

## PROCEDURE

Upon CCHP Portal or fax transmittal notification from a skilled nursing facility (SNF), an intermediate care facility for the developmentally disabled, a subacute care facility, or other LTC admission, or notification of hospital discharge to a SNF or LTC facility, CCHP places members based on appropriate level of care, as set forth in 22 California Code of Regulations (CCR) sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003e.

**Skilled Nursing Facility Long Term Care (Custodial):**

Upon receipt of a request for LTC (custodial) in a skilled nursing facility, CCHP requires the following documentation to support the request. This includes, but is not limited to:

1. Facesheet
2. Most recent (within last quarter) Minimum Data Set (MDS) with the following sections completed:
  - a. Section C – Cognitive Patterns
  - b. Section GG – Functional Abilities
  - c. Section Q – Participation in Assessment and Goal Setting
3. Progress notes from social services

The UM Nurse will review the documentation. Medical necessity requires that member has a medical condition that needs visits by a physician at least every 60 days and constantly available skilled nursing services, consistent with criteria outlined in Title 22 CCR section 51335.

The following criteria and guidelines will be used to determine medical necessity:

1. The member must meet the following requirements:
  - a. Have a cognitive impairment; and/or
  - b. A functional impairment; and
  - c. Have a need for 24/7 supervision

Authorization for LTC may be approved for up to 365 days based on medical necessity.

In the event that a member does not meet the criteria and guidelines outlined above, the request will be reviewed by the UM Medical Director or Medical Consultant for secondary review. If it is determined that medical necessity is not met, CCHP will consider approval for a short-term stay to allow necessary transition planning to a community-based setting. CCHP will submit a referral to Enhanced Care Management (ECM) to facilitate the transition.

**Benefit Requirements:**

CCHP places members in LTC Facilities that are licensed and certified by the CDPH. (See CR 11.013) and that are enrolled in Medi-Cal. Effective January 1, 2023, CCHP will authorize and cover medically necessary SNF services (provided in both freestanding and hospital-based facilities). CCHP will ensure that members in need of SNF services are placed in a health care facility that provides the level of care most appropriate to the member's medical needs.

As part of Basic Population Health Management (BPHM), CCHP will provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months.

For drugs provided by the SNF and billed on a medical or institutional claim, CCHP is responsible. CCHP may also choose to cover drugs that are not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered. CCHP will comply with the Population Health Management (PHM) requirements, which include coordination of medically necessary drugs or medications on behalf of the member.

CCHP will 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, including for carved-out Medi-Cal services.

**Leave of Absence of Bed Hold Requirements:**

CCHP will ensure that provision of a leave of absence/bed hold that a SNF provides is in accordance with the requirements of Title 22 CCR section 72520 or California's Medicaid State Plan. CCHP will allow the

member to return to the same SNF where the member previously resided under the leave of absence/bed hold policies in accordance with the Medi-Cal requirements for leave of absence and bed hold. CCHP will also ensure that SNFs notify the Member or the Member's authorized representative in writing of the right to exercise the bed hold provisions. CCHP will regularly review all denial of bed holds. CCHP will also provide transition assistance and Care Coordination to a new SNF when a SNF claims an exception under the bed hold regulations or fails to comply with the regulation.

## **Subacute Care Facilities**

### **Benefit Requirements:**

CCHP places members in LTC Facilities that are licensed and certified by the CDPH. (See CR 11.013) and that are enrolled in Medi-Cal. CCHP will cover Medically necessary adult subacute services and pediatric subacute care services (provided in both freestanding and hospital-based facilities). CCHP will ensure that members in need of adult or pediatric subacute care services are placed in a health care facility that provides the level of care most appropriate to the member's medical needs. CCHP will ensure that if a member needs adult or pediatric subacute care services, they are placed in a health care facility that is under contract for subacute care with DHCS's Subacute Contracting Unity (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

For drugs provided by a Subacute Care facility and billed on a medical or institutional claim, including physician administered drugs, CCHP will be responsible. CCHP may choose to cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered by Medi-Cal.

CCHP will cover all Medically Necessary services covered under the CCHP contract for members residing in or obtaining care in a Subacute Care Facility, including facility services, professional services, and ancillary services.

### **Access to Care**

As part of the provision of medically necessary covered services for members residing in or obtaining care in a Subacute Care Facility, CCHP will comply with existing Authorization/Utilization management policies to ensure that members will have access to routine and unusual specialties, covered medically necessary dental services, medically necessary behavioral health care services. CCHP will also ensure that standing referrals are reviewed and managed appropriately. CCHP will also ensure the timely provision of access standards for appropriate clinical timeframes, standards for timely specialty appointments, shortening or expanding timeframes, and arranging timely appointments when there is a provider shortage. CCHP will also ensure access for disabled members pursuant to the Americans with Disabilities Act of 1990. CCHP will also provide medically necessary services through Out-of-Network providers, including allowing access for the completion of Covered Services by an Out-of-Network provider or terminated provider.

### **Leave of Absence or Bed Hold Requirements:**

CCHP will provide continuity of care for members that are transferred from a Subacute Care Facility to a general acute care hospital and then require a return to a Subacute Care Facility level of care due to medical necessity. Requirements regarding leave of absence, bed hold, and continuity of care policies apply. CCHP will ensure the provision of a leave of absence (LOA)/bed hold by a Subacute Care Facility in accordance with the requirements of 22 CCR section 72520 and California Medicaid State Plan. CCHP will allow the member to return to the same Subacute Care Facility where they previously resided under the LOA/bed hold policies subject to medical necessity in accordance with the Medi-Cal requirements for LOA and bed hold. CCHP will ensure that a Subacute Care Facility notifies the Member or the Member's

authorized representative in writing of the right to exercise the bed hold provision. CCHP will also ensure that Members have the right to return to the Subacute Care Facility and to the same bed, if available, or at a minimum to the next available room in the facility, regardless of the duration of hospitalization.

CCHP will regularly review all denials of bed holds. CCHP will also provide transition assistance and care coordination to a new Subacute Care Facility when a Subacute Care Facility claims an exception under the bed hold regulations or fails to comply with regulations.

#### Treatment Authorization Requests:

Effective January 1, 2024, for members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, CCHP is responsible for covering treatment authorization requests (TARs) that are approved by DHCS and provided under the Subacute Care Facility per diem rate for a period of six months after enrollment into CCHP, or for the duration of the TAR approval, whichever is shorter. CCHP will honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, authorized representative, or Provider. CCHP may approve subsequent reauthorizations for up to six months. Reauthorizations may be approved for one year for Members who have been identified or meet the criteria of “prolonged care.”

Effective January 1, 2024, for Member residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal Managed Care, CCHP is responsible for covering all other services in TARs approved by DHCS (except for supplemental rehabilitation therapy services and ventilator weaning services for Members in pediatric Subacute Care facilities) provided in a Subacute Care Facility exclusive of the Subacute Care Facility per diem rate for a period of six months after enrollment in CCHP, or for the duration of the TAR, whichever is shorter. CCHP will honor and cover the service(s) under the DHCS-approved TAR without a request by the Member, authorized representative, or Provider. CCHP may approve subsequent reauthorizations for up to six months. Reauthorizations may be approved for one year for Members who have been identified or meet the criteria of “prolonged care.”

Supplemental rehabilitation therapy services and ventilator weaning services may be separately authorized and reimbursed for eligible pediatric subacute patients. Reimbursement for these services is in addition to the per diem rate for pediatric subacute level of care services. An approved TAR is required for these services.

Effective January 1, 2024, for pediatric Members residing in a Subacute Care Facility who are transitioning from Medi-Cal FFS to Medi-Cal managed care, CCHP is responsible for covering supplemental rehabilitation therapy services and ventilator weaning services for TARs approved by DHCS in a Subacute Care Facility for a period of three months after enrollment in CCHP. CCHP will honor and cover the service(s) under the DHCS-approved TAR without a request by the member, authorized representative, or Provider. CCHP may approve subsequent reauthorizations for up to three months.

Approval for pediatric subacute care services cease once the Member turns 21 years of age. Discharge planning to an adult Subacute Care Facility must be completed at least two months prior to the Member turning 21 years of age.

Treatment Authorization Forms should also appropriately identify whether a member needs subacute care services: Form 6200 for pediatric subacute care services and Form 6200A for adult subacute care services. CCHP utilizes a portal for authorization requests. The portal request pertaining to adult and pediatric subacute care service requests will require submitting information that is specified in Forms 6200 and Form 6200A. For providers that submit adult and pediatric subacute care service requests through non-portal means (i.e. fax) – the relevant form, Form 6200 or 6200A, will need to be completed to process and review the request.

## **Subacute Care Adult Eligibility Criteria:**

CCHP utilizes Medi-Cal guidelines for Utilization Review of Subacute Care Programs

To qualify for the subacute program, the member must need one of the following

- Tracheostomy care with continuous mechanical ventilation for at least 50 percent of the day
- Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the six treatment procedures listed below
- Administration of any three of the six treatment procedures listed below

Treatment procedures include:

- Total Parenteral nutrition
- Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week
- Tube feeding (nasogastric or gastrostomy)
- Inhalation therapy treatments every shift and a minimum of four times per 24-hour period
- Intravenous therapy involving:
  - The continuous administration of a therapeutic agent, or
  - The need for hydration, or
  - Frequent intermittent intravenous drug administration via a peripheral and/or central line
  - Debridement, packing, and medicated irrigation with or without whirlpool treatment

## **Pediatric Subacute Care Programs**

CCHP utilizes Medi-Cal guidelines for eligibility criteria for pediatric subacute care programs.

### **Eligibility Criteria:**

To qualify for the pediatric subacute program, the patient must be under 21 years of age and need one of the following:

- 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 air mist or oxygen as needed, and dependence on one of the five (b through f) treatment procedures listed below
- Total parenteral nutrition or other intravenous nutritional support and one of the six (a through f) treatment procedures listed below -
- Skilled nursing care in the administration of any three of the six (a through f) treatment procedures listed below
- Bi-phasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence on one of the five treatment procedures in (a) to (e) below -

### **Treatment Procedures:**

Treatment procedures include:

- a. Intermittent suctioning at least every eight hours and room air mist or oxygen as needed.

- b. 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.
- c. Peritoneal dialysis treatments requiring at least four exchanges ever twenty-four hours.
- d. Tube feeding via nasogastric or gastrostomy tube.
- e. Other medical technologies required continuously, which in the opinion of the attending physician and the CCHP medical consultant require the services of a professional nurse.
- f. Bi-Phasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence one of the five treatment procedures in (a) to (e).

Attachment A.

### **Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-DD):**

#### Benefit Requirements

CCHP places members in LTC Facilities that are licensed and certified by the CDPH. (See CR 11.013) and that are enrolled in Medi-Cal. Effective January 1, 2024, CCHP will provide all medically necessary covered services for members residing in or obtaining care in an ICF/DD home, including home services, professional services, ancillary services, and transportation services. CCHP will also provide the appropriate level of care coordination. CCHP will also authorize and cover Medically Necessary ICF/DD Home services, consistent with definitions in the Medi-Cal Provider Manual. The list of services that are included and excluded from the ICF/DD, ICF/DD-H, and ICF/DD-N Home's per diem are established in 22 California Code of Regulations and listed in Attachment A.

For members who are dually Medicare and Medi-Cal covered, CCHP will coordinate and address coverage needs, regardless of payer source. CCHP will cover LTC ICF/DD Home benefits.

As of January 1, 2024, CCHP will coordinate transportation services between CCHP and the ICF/DD Home. CCHP will cover Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) as set forth in CCHP contract and APL 22-008. Day program and related transportation will continue to be provided by ICF/DD homes and are not a responsibility of CCHP.

For drugs provided by the ICF/DD home and billed on a medical or institutional claim, CCHP will be responsible. CCHP may also choose to cover drugs that are not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered.

#### Access to Care

As part of the provision of medically necessary covered services for members residing in or obtaining care in an ICF-DD home, CCHP will comply with existing Authorization/Utilization management policies to ensure that ICF-DD members will have access to routine and unusual specialties, covered medically necessary dental services, medically necessary behavioral health care services. CCHP will also ensure that standing referrals are reviewed and managed appropriately. CCHP will also ensure the timely provision of access standards for appropriate clinical timeframes, standards for timely specialty appointments, shortening or expanding timeframes, and arranging timely appointments when there is a provider shortage. CCHP will also ensure access for disabled members pursuant to the Americans with Disabilities Act of 1990. CCHP will also provide medically necessary services through Out-of-Network providers, including allowing access for the completion of Covered Services by an Out-of-Network provider or terminated provider.

#### Leave of Absence and Bed Hold Requirements:

CCHP will comply with regulations regarding leave of absence (LOA) and bed hold policies. CCHP will cover the stay when members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute care setting, such as a skilled nursing facility (SNF), or a rehabilitation facility, and then require a return to an ICF-DD home. CCHP will include as a covered benefit any LOA or bed hold that an ICF/DD Home provides. CCHP will authorize up to 73 days per calendar year for an LOA. A physician signature is required for an LOA only when a member is participating in a summer camp for the developmentally disabled. For a bed hold, CCHP will authorize up to a total of 7 calendar days per hospitalization. The ICF/DD home shall hold a bed vacant during the entire hold period – a maximum of seven days for each bed hold period – but is not required to hold the bed if notified in writing by the attending physician that the patient requires more than seven days of hospitalization.

CCHP will also allow the member to return to the same ICF/DD home where the member previously resided if it is the member's preference. CCHP will ensure that the ICF/DD home notifies the member or the member's authorized representative in writing of the right to exercise the bed hold provision. If a member does not wish to return to the same ICF/DD home following a LOA or approved bed hold period, CCHP will provide care coordination and transition support, including working with the assigned Regional Center, in order to assist the Member to identify another ICF/DD Home within CCHP's network that can serve the Member. The Regional Center will take the lead on discharge and transition planning if the Member wishes to transition to a non Medi-Cal funded living situation with input from other stakeholders, such as the hospital, the original ICF/DD home, and CCHP. CCHP will take the lead on discharge and transition planning if the Member chooses to transition to a different Medi-Cal level of care, in collaboration with the Regional Center.

#### Continuity of Care Requirements:

ICF/DD homes are a long-term home living setting. While CCHP works to bring ICF-DD homes into their network, CCHP will ensure continuity of care, in that a member's ICF/DD home will not change for at least 12 months. During this continuity of care period, CCHP will automatically provide 12 months of continuity of care for the ICF/DD home placement of any member residing in an ICF/DD home who is mandatorily enrolled into CCHP after January 1, 2024.

CCHP will allow members to stay in the same ICF/DD home under continuity of care if the member chooses to continue living in the ICF/DD home and all of the following apply:

- The ICF/DD home is licensed by CDPH.
- The ICF/DD Home is enrolled as a Medi-Cal provider.
- CCHP will pay the ICF/DD home payment rates that meet state statutory requirements, and
- The ICF/DD home meets CCHP's applicable professional standards and has no disqualifying quality-of-care issues.

Following their initial 12-month continuity of care period, Members or their authorized representatives may request an additional 12 months of continuity of care.

A member residing in an ICF/DD home who newly enrolls in CCHP on or after January 1, 2024, or their authorized representative, who wishes to request an additional 12 months of continuity of care must follow the process established by APL 23-022.

Under continuity of care, members may continue seeing their Out-of-Network Medi-Cal provider if the member, authorized representative, or Provider contacts CCHP to make the request. CCHP must provide continuity of care for all medically necessary ICF/DD Home services for members residing in an ICF/DD home at the time of enrollment in CCHP, including professional services, ancillary services, and transportation services not already provided in the ICF/DD home per diem rate.

Members may continue seeing their existing Out-of-Network Medi-Cal provider for up to 12 months after

enrollment when the following conditions are met:

- The member has a pre-existing relationship with the provider, defined as having seen the provider for at least one non-emergency visit in the prior 12 months.
- The provider meets CCHP's professional standards and has no disqualifying quality of care issues.
- The provider is willing to work with CCHP.

CCHP must also allow members to maintain current drug therapy, including non-formulary drugs, until the member is evaluated or re-evaluated by a network provider. CCHP is responsible for drugs furnished by a provider and billed on a medical or institutional claim. CCHP may also choose to cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered by Medi-Cal.

Treatment Authorizations:

Effective January 1, 2024, CCHP is responsible for TARs approved by DHCS for ICF/DD Home services provided under the ICF/DD home per diem rate for the duration of the treatment authorization for existing authorization requests and for up to two years for any new requests.

CCHP is responsible for all other approved authorization requests for services in an ICF/DD home, exclusive of the ICF/DD home per diem rate for a period of 90 days after enrollment in CCHP, or until CCHP is able to reassess the member and authorize and connect the member to medically necessary services.

Routine authorizations are subject to a turnaround time of five working days.

Effective January 1, 2024, ICF/DD homes will continue to submit the Certification for Special Treatment Program Services form HS 231 to CCHP with any initial or reauthorization requests. CCHP will accept the Certification for Special Treatment Program Services form HS 231 as evidence of the Regional Center's determination that the Member meets the ICF/DD Home level of care. An initial authorization may be granted for periods up to two years from the date of admission. Reauthorizations may also be granted for up to two years.

### **Summary of Services Included in ICF/DD Carve-In Per Diem Rate**

- Summary: All services, equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria.
- Active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services per 42 CFR section 483.440
- Case conference review of member's developmental needs
- Joint development of individual service plans
- In-service training of direct care staff and follow-up to ensure proper implementation of individual service plan.
- Advising on the need for provision of various types of intervention or specialized equipment beyond the capabilities of the facility or staff
- Administrative services
- Health support, food and nutritional and pharmaceutical services<sup>63</sup> social services
- The provision of routine and emergency drugs and biologicals to its members. Drugs and biologicals may be obtained from community or contract pharmacists, or the facility may maintain a licensed pharmacy.

- Services usually required by persons with developmental disabilities. However, actual programs provided to members shall be based on the specific needs identified through member assessments.
  - Examples include sensory motor development, self-help skills training, and behavioral intervention programs
- Transportation services when necessary for round trips to attending physicians.
- Habilitation Program which shall include recreation, education, and effective use of leisure time and socialization skills.
- Early and Periodic Screening and Diagnosis and Treatment (EPSDT\_
- Specific equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria\*\*\*
  - \*\*\* Inclusive of only ICF/DD-N. “Specific equipment and supplies” refers to equipment and supplies that can be used by more than one person that are necessary to provide Level of Care for this type of facility. Equipment that is specific to an individual and cannot be used by others is excluded from per diem (i.e., Custom wheelchair)

### **Long Term Services and Supports (LTSS) Liaison**

CCHP will identify and maintain a Long-Term Services and Supports Liaison to serve as a liaison for the Long-Term Services and Supports Provider Community. CCHP’s Director of Case Management will serve in this role. The LTSS liaison is not required to be credentialed/licensed, but will have the ability to support the ICF/DD population’s service needs. This staff member will be trained by the Plan to identify and understand the full spectrum of Medi-Cal long term care, including payment and coverage rules. The liaison will serve as the single point of contact for service providers in a Provider representative role. Responsibilities of the LTSS include, but are not limited to:

- Work with Transitional Care Services (TCS) Staff to support care transitions, as needed.
- Assist service providers in addressing claims and payment inquiries in a responsive manner.
- Assist with care transitions among the LTSS provider community to best support a member’s needs
- Work closely with CCHP departments and staff to address any ICF-DD issues pertaining to Member or Provider

CCHP will ensure that the contact information of the LTSS is disseminated to Network Providers. CCHP will also notify Network Providers of any changes to the LTSS liaison assignment expeditiously in order to ensure co-ordination and services officered to Members.

### **Utilization Review Process**

Upon identification that a member needs LTC services, the acute hospital case manager or discharge planner will coordinate the transition to the LTC facility and provide clinical documentation pertinent to the care of the member. Documentation shall be sent to the LTC facility within one business day of the admission and includes the member’s health status and plan of care. For ICF-DD facilities, this may require coordination with the member’s Regional Center. The transition from LTC to the next level of care may include coordinating the following:

1. Discharge home with home health or outpatient services.
2. Assisting the member with making financial arrangements for continued care in the LTC facility.
3. Determining linkage to alternative financial and community resources, i.e., Medi-Cal, Medicare, long-term care insurance, in-home support services, Providing Assistance to Caregivers in Transition (PACT), etc.

4. Identifying members who may potentially exhaust his/her LTC benefits while hospitalized in the LTC facility and collaborate with the member, family, and the LTC facility to implement a plan of action that focuses on, as much as possible, providing continuity of care.

Concurrent review occurs after the initial admission review on a regular basis, no more than every two weeks and no less than every twelve months, for medical necessity, severity of illness and intensity of service (SI/IS) and other factors that determines the appropriateness of the admission.

If a stay continues to meet criteria for continuation of acute or skilled level of care, the UM Nurse confirms the date of admission, documents this in ccLink, and continues regular concurrent review. It is the responsibility of the facility to send updated clinical documentation on a daily basis to CCHP to facilitate this concurrent review. Records not provided in a timely manner may result in nonpayment. Concurrent review continues until the member is discharged, transferred to a lower level of care, or discharged home.

When the UM nurse determines an initial or concurrent stay review does not meet acute or skilled care guidelines, the case is referred to the Chief Medical Officer or physician designee. Upon review, the Chief Medical Officer may contact the attending physician to ascertain the current level of care and/or treatment plan. Only the Chief Medical Officer or designee can deny or modify an inpatient stay based on medical necessity. Depending upon product line, the UM nurse sends a facility notification or denial notice (along with appeal rights) to member and provider explaining the principle/clinical reason(s) for continued stay and payment denial. Notification of a hospitalization after the member is discharged is not considered a concurrent review and will be processed as a post-service (retroactive) authorization request and may result in nonpayment. (Refer UM15.011 - Inpatient Utilization Review)

**References:**

- California Department of Health Care Services (DHCS) **Medi-Cal LTC Care Program Guidelines**. <https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx>
- Cal. Admin. Code tit. 22, § 51335, 22 CA ADC § 51335
- **Medi-Cal Long-Term Care (LTC) Benefit Guidelines**. The Manual of Criteria for Medi-Cal Authorization is available at: [https://www.dhcs.ca.gov/formsandpubs/publications/Documents/MediCal\\_PDFs/Manual\\_of\\_Criteria.pdf](https://www.dhcs.ca.gov/formsandpubs/publications/Documents/MediCal_PDFs/Manual_of_Criteria.pdf).
- ALL PLAN LETTER 24-009: SKILLED NURSING FACILITIES -- LONG TERM CARE BENEFIT STANDARDIZATION AND TRANSITION OF MEMBERS TO MANAGED CARE: <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-009.pdf>
- California Department of Health Care Services (DHCS) **Medi-Cal Subacute Care Program Guidelines**. <https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx>
- **Medi-Cal Sub-Acute Long-Term Care (LTC) Benefit Guidelines**. The Manual of Criteria for Medi-Cal Authorization is available at: [https://www.dhcs.ca.gov/formsandpubs/publications/Documents/MediCal\\_PDFs/Manual\\_of\\_Criteria.pdf](https://www.dhcs.ca.gov/formsandpubs/publications/Documents/MediCal_PDFs/Manual_of_Criteria.pdf).
- ALL PLAN LETTER 24-010, SUBACUTE CARE FACILITIES -- LONG TERM CARE BENEFIT STANDARDIZATION AND TRANSITION OF MEMBERS TO MANAGED CARE: <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-010.pdf>