Government Business Division
Policies and Procedures

Section (Primary Department) **Case Management**	**SUBJECT (Document Title)** **Skilled Nursing and Long Term Care Services - CA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
06/10/1999	10/28/2024	10/28/2024	10/28/2024

Department Approval/Signature:

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross (Anthem) Medicaid ensures access to certified skilled nursing and long-term care (LTC) services to members. The Medical Management (includes both utilization and case management) staff review for skilled nursing services and initiates referrals to the LTSS team when a need or when long term care services are identified.

Long Term Care facilities may include:

- Skilled Nursing Facilities
- Sub-acute Facilities (pediatric and adult)
- Intermediate Care Facilities
- Hospitals that provide Administrative Bed Days in their Contract

DEFINITIONS:

Alternative benefit – Non-covered services provided by Anthem Medicaid in order for a member to obtain medically appropriate care in a more economical and cost-effective way.

Intermediate Care Facilities – Intermediate care services means services provided in hospitals, skilled nursing facilities or intermediate care facilities to patients who:

1) Require protective and supportive care, because of mental or physical conditions or both, above the level of board and care.
2) Do not require continuous supervision of care by a licensed registered or vocational nurse except for brief spells of illness.
3) Do not have an illness, injury, or disability for which hospital or skilled nursing facility services are required.

Long Term Care – For Medi-Cal members, Long Term Care is defined as care provided for patients who are considered custodial care and not presently needing skilled care. For Medi-Cal members, the definition of LTC excludes hospice services, regardless of the expected or actual length of stay in a nursing facility.

Skilled Nursing Facilities – provide a level of care needed by a member who does not require hospital acute care but who requires skilled nursing care. The need must be for a level of service which includes the continuous availability of procedures such as, but not necessarily limited to, the following: administration of intravenous, intramuscular, or subcutaneous injections, and intravenous or subcutaneous infusions; gastric tube or gastrostomy feedings; nasopharyngeal aspiration; insertion or replacement of catheters; application of dressings involving prescribed medications and aseptic techniques; treatment of extensive decubiti and other widespread skin disorders; heat treatments which require observation by licensed personnel to evaluate the patient's progress; administration of medical gases under prescribed therapeutic regimen; and restorative nursing procedures which require the presence of a licensed nurse. Other health care services, such as physical, occupational or speech therapy, require specialized training for proper performance. The need for such therapies does not necessarily indicate a need for nursing facility services.

Sub-acute Facilities – Sub-acute level of care means a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility, such as ventilator dependent members

PROCEDURE:

A. Medi-Cal

I. As part of the discharge planning process, the UM staff will assist the acute facility with members needing post-acute care in a skilled nursing facility. Those requests will be reviewed for medical necessity and a determination will be made within 72H of the facilities request. Concurrent review will continue until a member is discharged to another setting or determined to need LTSS services (transitional care services). For those members who are anticipated to require LTC the LTSS service coordinator will work with the providers to create a care plan and coordinate the LTC benefit.

II. The Anthem Medicaid physicians, institutions, health care clinicians, and/or Medical Management staff identify a member in need of a long-term care facility. Member will be referred to Anthem Long Term Support Services (LTSS) team for coordination of benefits.

III. The physician/facility requests prior authorization for long-term care services. If needed, the Medical Management staff assists the physician with finding a facility for the appropriate level of care needed.

IV. The primary care provider (PCP), in collaboration with hospital Discharge Planning, Care Management departments, and the Anthem Medicaid Case Management team, 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.

V. When the member does not meet the criteria for long term care or if placement is not available, the Medical Management staff continues to manage the case and authorizes all medically necessary services until the benefits are exhausted. The PCP/attending physician continues to coordinate treatment for the member.

B. MRMIP

I. MRMIP - Long Term Care may be provided as an alternative benefit.

II. Medical Management staff coordinates the benefits with the facility and notifies the member, physician, institution, and/or health care clinician accordingly.

C. Bed Holds

The Welfare and Institution Code section 72520 states bed holds are limited to a maximum of seven (7) days, after which the Skilled Nursing Facilities (SNFs) cannot bill for a bed hold. The bed hold must be requested by the SNF within 24H of being notified that the member will be admitted to the acute hospital. If the member stays in the acute hospital past the seven (7) days, the SNF is no longer required to hold the bed or allowed bill for bed hold days.

REFERENCES:

- 42 CFR Section 483.15(e)(1) and (c)
- Anthem Policy CA_CAXX_001 Transitional Care Services
- California Code of Regulations, Title 10 Section 2698.302(a)(11)
- California Code of Regulations, Title 10 Section 2699.6703 (a) (10)

- Central Valley/Bay Area, Tulare, Sacramento, and Tri-county (Fresno, Kings, Madera) Contracts, Exhibit A, Attachment 11.
- DHCS All Plan Letter 17-017 Long Term Coordination and Disenrollment (Oct 27, 2017)
- DHCS All Plan Letter 23-004 Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- DHCS APL 23-027 "Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care"
- DHCS dual plan letter 14-002 Requirements For Nursing Facility Services
- MRMIP, Medi-Cal, LA Care Evidence of Coverage 2023
- Provider Operations Manual, January 2023
- Title 22, Sections: 50056, 51120, 51124, 51124.5, and 51124.6
- Welfare and Institution Code section 72520

RESPONSIBLE DEPARTMENTS:

Primary Department:
Case Management (CM)

Secondary Department(s):
Long-Term Services and Supports (LTSS)

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
10/28/24	• Annual Review • Updated definition of Long Term Care
06/17/24	• Off-Cycle Review • Updated Policy and Procedure sections • Removed UM as a secondary department
10/26/23	• Annual Review • Updated Procedure and References sections
03/31/23	• Off-Cycle Review • Added "Transitional Care Services" under Procedure section, A • Updated References section
12/19/22	• Early Annual Review

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Review Date	Changes
	• Updated policy name from "Long Term Care Services – CA" to "Skilled Nursing and Long Term Care Services – CA" • Updated Policy, Procedure and References sections to include new contract and LTC carve in for 01/01/2023 • Revised primary department name under Responsible Departments section from "Medical Management: Utilization Management (UM) & Case Management (CM)" to "Case Management" to match Primary Department name in policy header • Added LTSS and UM as secondary departments under Responsible Departments section • Added header on Revision History Table to match GBD template
03/24/22	• Annual Review • Updated References and placed in alphabetical order
03/11/21	• Annual Review • Update References • Removed AIM
03/11/20	• Annual Review • Updated references • Added language from APL 17-017
03/06/19	• Annual Review, Updated References
03/20/18	• Annual Review. Updated References
03/31/17	• Added "members in LA and Santa Clara counties are referred"
04/29/16	• Annual Review, no changes
05/30/15	• Removed Healthy Families • Added LA and Santa Clara not to be disenrolled • Updated References
06/20/14	• Removed instances whereby LTC will be sent for disenrollment • Updated References
06/17/13	• Clarified benefit for Healthy Families members to more closely match the description found in the California Code of Regulations. • Some reformatting for improved flow • Updated references.
08/29/12	• Added SPD to applicable plans • Changed references from Anthem BCBS to Anthem Medicaid • Updated procedure section to improve flow • Clarified LTC coverage for AIM, MRMIP, and Healthy Families • Updated references • Added revision history to policy