Santa Clara Family Health Plan™

Skilled Nursing Facility Reference Guide

Provider Network Operations:

ProviderServices@scfhp.com

1-408-874-1788, Monday through Friday, 8:30 a.m. to 5:00 p.m.

www.scfhp.com

Updated: 08/2022

Contents

Section 1 - Introduction and getting started

Purpose of this guide

The purpose of this guide is to provide information specific to Skilled Nursing Facilities (SNF), Subacute, and Intermediate Care Facilities (ICF) to supplement content published on our website and in the Santa Clara Family Health Plan (SCFHP) Provider Manuals. Please visit the Provider Resources page at www.scfhp.com for additional tools and information.

This guide primarily addresses SCFHP operations for Long-Term Care (LTC) members with some reference to skilled level of care where differences may apply. You may address questions about utilization management or care coordination for skilled level of care by contacting **1-408-874-1821**.

Provider Network Associate – Long-Term Services and Supports (LTSS)

SCFHP offers a dedicated Provider Network Associate (PNA) to assist contracted nursing facilities with communications, training, and resolutions that may include Utilization Management (UM), billing, payment inquiries, and referrals to other SCFHP departments as needed. The PNA will respond to calls regarding billing and payment matters within two (2) business days. Nursing facilities with questions about claims, claims processing, rates, or payment should contact the PNA by email at LTSSHelpDesk@scfhp.com. To request a site visit, please email LTSSHelpDesk@scfhp.com.

For additional information about member benefits, please refer to the SCFHP Member Handbook at www.scfhp.com. And visit the Long-Term Services and Supports page for more guidance on services, key contacts, and activities under long-term care.

Definitions

Skilled care: Refers to skilled nursing services and skilled rehabilitation services that must be provided by or performed under the supervision of licensed medical personnel. A physician or certified nurse practitioner prescribes skilled care services.
Example: Someone discharged from the hospital to an SNF for rehabilitation from a broken hip.

Long-term care (LTC): Provides non-skilled care (i.e., custodial care) that non-licensed personnel can safely perform. LTC assists with daily living, including:

- Assistance getting in and out of bed
- Assistance with feeding
- Assistance with bathing, toileting, and dressing

SCFHP recognizes that at times, Skilled Nursing Facilities (SNFs) may provide skilled care (Medicare) and offer prolonged stays for Medi-Cal and Sub-Acute services within the same facility.

Communicating by electronic mail

To ensure privacy and security of member information under the Health Insurance Portability and Accountability Act (HIPAA), always use a secure email method for communications. If you do not have a secure email, please ask an SCFHP employee to send you a secure email. Using that secure email will allow for a direct and secure reply to the originator.

Avoid using member identifying information in an unsecured email. For example, do not use a member's name, date of birth, or ID. In addition, refrain from using any member identifying information in the subject line of an email for privacy and security reasons.

Please contact your Information Systems Department for additional information about secure email services available at your facility.

For basic training on HIPAA, please refer to our Provider Resources page.

Credentialing and contracting inquiries

Provider Network Operations (PNO) is responsible for credentialing and contracting. Please email providerservices@scfhp.com for questions or needs related to the topics below:

- Credentialing process and status of an application
- Rate questions
- Change of ownership and name change requests
- Change of ownership amendments
- Difference between Cal MediConnect and Medi-Cal contracts
- Per diem rates for skilled and long-term care services
- AB1629 annual adjustments
- Contracting or rate of special projects or questions

Section 2 - Utilization management & LTC authorizations

SCFHP conducts utilization management (UM), authorization, and concurrent review as part of normal business operations. Please refer to our Provider Manuals for additional information on the medical services and procedures that require prior authorization and review as well as our decision process.

Medical services & procedures requiring prior authorization in a Skilled Nursing Facility (SNF)

Medical services that require prior authorization from SCFHP are listed in the Prior Authorization Reference Guide on our website. Facilities may submit a request for prior authorization by completing the Prior Authorization Request (PAR) form and faxing it to **1-408-874-1957**. Please attach clinical documentation as indicated on the form. For long-term authorizations, a separate Long-Term Care Authorization Form is required. Each request is approved based on medical review, the level of care, and short or long-term duration requirements.

Providers working with delegated entities in our networks should submit the request to the applicable UM Department for that organization (i.e., Valley Health Plan (VHP), Physicians Medical Group of San Jose (PMG), and Premier Care).

Tracking a prior authorization request

Providers may log in to Provider Link, our provider platform at providerportal.scfhp.com, to review the status of authorizations, service date details, and quantity of services approved. For further questions and clarifications about the status of prior authorization requests, providers may contact SCFHP UM Department at **1-408-874-1821**.

LTC admissions to SNF from hospital

When a member transfers from a hospital to a facility for LTC services, the SNF will send the request along with the physician (MD) orders, the History of Present Illness (HPI) from the hospital, and current care plan. An authorization request is then created and reviewed. If approved, the initial authorization will be for six months to a year based on medical necessity.

LTC admissions to SNF from home

The process is similar to the above except that the initial authorization will be for one week to allow for care plan development. Once the care plan is developed, the SNF must submit a new Long-Term Care Authorization Form and request an extension, also known as a continued stay.

LTC reauthorization requests

When a member needs continued LTC services while at the SNF, a reauthorization request for LTC can be made for three, six, or twelve months. Please submit a Long-Term Care Authorization Form along with the current and required documents listed on the form.

Expedited requests

In medically urgent situations, the SNF may request an expedited PAR review by faxing the completed form to **1-408-874-1957** and by contacting the UM Department at **1-408-874-1821**.

For all lines of business, expedited authorization requests will be reviewed and decisions issued within 72 hours from the date the SCFHP UM Department received the request.

SCHFP will notify the SNF of the decision by a phone call, followed by written notification, within three calendar days of the determination. Non-urgent PARs are reviewed and determination reached within five business days from the date of receipt for Medi-Cal and within 14 calendar days from the date of receipt for Cal MediConnect.

Prior authorizations for ancillary services

When ancillary services such as home health care, medical supplies, rehabilitation services, and durable medical equipment (DME) are required, the UM Department works with the physician to select an appropriate in-network provider based on the member's medical needs. UM assists the provider and member with obtaining timely access to these services. Prior authorization is required for these services, including documentation of medical necessity and a prescription signed by the ordering physician.

As part of the prior authorization process, the primary care physician (PCP) or prescribing physician must send the request to the selected contracted ancillary provider to arrange for service.

Ancillary services requiring a PAR may include, but are not limited to, the following:

- Durable medical equipment (purchase or rental)
- Dialysis
- Eye appliance services
- Hearing devices/audiology services
- Home health agency services
- Medical supplies
- Outpatient services

Please refer to our website for prior authorization requirement guidance to determine whether a PAR is needed for a specific service, www.scfhp.com/for-providers/provider-resources/prior-authorization/.

Concurrent review & discharge planning

Concurrent review refers to assessing the medical need and appropriateness of health services rendered for a member's ongoing care. SCFHP routinely conducts concurrent review for members receiving skilled nursing services and works with skilled nursing facilities to ensure members safely transition back to the community or long-term/custodial care when appropriate.

Discharge planning refers to coordinating discharge from a facility with the member, family, authorized representative, Interdisciplinary Care Team (ICT), and the health plan. The discharge plan addresses a member's anticipated continuing care needs following the discharge from the nursing facility. Initial evaluation for discharge planning begins at the time of notification of inpatient admission.

The key to a successful transition and SCFHP census management is timely coordination of the discharge planning process with SCFHP. The LTSS team can assist with education and access to LTSS benefits. In addition, the UM Department provides support by authorizing benefits needed for discharge such as DME, home health, and outpatient services. For more information, please see Section 7 Case Management and Care Transitions.

A comprehensive written discharge plan includes, but is not limited to, the following:

1. Documentation of:
    a. Pre-admission status, living arrangements, physical and mental function, social supports, DME, and other services received.
    b. Pre-discharge factors: member's understanding of condition and treatment, physical and mental function, financial resources, living arrangement, and social supports.
2. Evaluation of financial, psycho-social, and potential post-discharge service needs such as type of preferred placement, home health care, DME, long-term services and supports, and hospice.
3. Discussion and agreement on the discharge plan by the member and Interdisciplinary Care Team (ICT).
4. Planned discharge date.

For additional reference, our Nursing Home Pre-Discharge Checklist is available as a resource here: www.scfhp.com/for-providers/long-term-services-and-supports/.

Section 3 - Member eligibility and delegation

Santa Clara Family Health Plan has two plans:

1. SCFHP Medi-Cal Plan
2. SCFHP Cal MediConnect Plan (Medicare-Medicaid Plan)

For more information about our lines of business, please visit www.scfhp.com.

Member eligibility checks

SCFHP recommends providers check member eligibility each time a member wishes to access services and each month after that. Check member eligibility by using the following methods:

- Logging in to Provider Link at providerportal.scfhp.com to download member rosters.
- Calling our automated IVR line at **1-408-874-1473** to verify member eligibility.
- Calling SCFHP Provider Services at **1-408-874-1788**, Monday through Friday, 8:30 a.m. to 5:00 p.m.

AEVS Medi-Cal eligibility information may also indicate whether the member has a share of cost, and the amount. SCFHP receives both daily and monthly updates directly from Medi-Cal, which include systemic changes related to a member's address, line of business, share of cost, and a brief summary of the managed care plan. Medi-Cal does not include the managed care organization's delegate assignment, but this information is available on Provider Link.

In addition to verifying member eligibility, it is essential to coordinate and receive payment for covered services. Utilization of eligibility tools helps to determine if the member is eligible for benefits on the date of service, whether the member is enrolled in SCFHP, if they are assigned to a network (e.g., Valley Health Plan (VHP), Physician Medical Group (PMG), Premier Care, and Kaiser), and if the primary insurance coverage is with Medicare fee-for-service or other managed health plan.

Each staff member or billing group should have unique login credentials to access Provider Link. Registering for another staff member or sharing credentials with someone other than yourself is prohibited.

Avoid eligibility and claims mismatches

Be sure to bill with the appropriate authorization number for the eligible member's level of care, dates of service, and direct the bill to the applicable entity, delegated health plan, or delegate group.

Our Provider Network Associate (PNA) is happy to assist with any identified problems or concerns related to delegated networks and providers. For assistance with a prior authorization request or claim payment from a delegated group (e.g., Kaiser, Valley Health Plan, Physicians Medical Group, Premier Care), please email LTSSHelpDesk@scfhp.com. An Associate or Program Manager will reach out to assist you.

Eligibility and members who move out of Santa Clara County

Please contact SCFHP with any eligibility questions or concerns. Inform SCFHP of changes to member's physical address, most notably those moving out of Santa Clara County. This action does not replace the notification to Medi-Cal but can be done in parallel. In addition, please update and report on the best contact phone number for all SCFHP members discharging from your facility to ensure successful transition of care (TOC) calls.

Managed care member enrollment

All managed care member enrollments and dis-enrollments are conducted through Medicaid (Medi-Cal) policies and procedures. Once members are approved for Medi-Cal, they may choose a health plan in their county. At present, there are two Medi-Cal plans in Santa Clara County. If members cannot or do not select a health plan, one will be selected for them based on their history with specific doctors or facilities.

Enrollments are conducted monthly, and generally, a two-week lead time is needed for an effective date assignment. If an enrollment takes place prior to Medi-Cal's deadline, managed care benefits will begin on the first of the following month.

Members can change their Medi-Cal health plan at any time. If a member makes a request for a plan change before the middle of the month, the change is generally made effective on the first day of the effective month.

If you need assistance with disenrollment due to a transfer of a member to a different county, please coordinate this closely with Santa Clara Family Health Plan.

Please call Health Care Options (HCO) Coordinated Care Initiative at **1-844-580-7272**, Monday through Friday, 8:00 a.m. to 6:00 p.m. Or call SCFHP Provider Services at **1-408-874-1788**, Monday through Friday, 8:30 a.m. to 5:00 p.m.

Delegation rules for member assignments

The following information describes the model for submitting authorization requests and claims for members assigned to a delegated group.

- For SCFHP members assigned to a Long-Term Care Facility Primary Care Physician (PCP), authorization requests and claims go to SCFHP.
- For Premier Care, Kaiser, and Physicians Medical Group, there is a mixture of authorization, month of or month after, and payment rules.
    - For members assigned to Kaiser:
        - Kaiser authorizes and pays for the skilled facility claims.
            - SCFHP authorizes and pays for long-term care claims starting on the third month after the month of admission.
    - For members assigned to either Physicians Medical Group or Premier Care (PC), the group authorizes long-term care services for the month of admission and month after. Subsequent authorizations should be submitted to SCFHP.
        - SCFHP pays the skilled care claims.
    - For members assigned to Valley Health Plan (VHP), skilled care claims are the responsibility of VHP. Therefore, authorization requests and claims must be sent to VHP.
        - For long-term care, it is VHP's responsibility to process authorizations and claims for the entire month of admission. If SCFHP is not notified, VHP could be held responsible for longer.

The SCFHP Provider Link will reflect the most current eligibility and assignment, so you can determine where to submit your authorization request. Once members previously assigned to VHP under LTC are transitioned to SCFHP, use the Long Term Care Authorization Request Form to submit authorization requests to SCFHP.

Note: Sometimes members are admitted as skilled, then change to long-term care. These changes are closely managed through direct communications between SCFHP and VHP.

In summary, regardless of previous insurance or delegation assignment, the current date of admission becomes referred to as the “month of admission.” The current month of admission in skilled and long-term care is important in determining when the facility seeks prior authorization and payment. Depending on the division of responsibility (DOFR) between the delegated entities and SCFHP, there may also be differences if a member is assigned to a Primary Care Physician, remains with the delegated group, or if the eligibility is transitioned directly to SCFHP for authorization and/or payment.

When a member transitions from a delegated entity, the official transition date is the first of the month.

Section 4 - Claims management and rate updates

This section assumes the reader has training, background, and experience in billing facility claims. Because SCFHP does not actively provide training on claims billing, we refer providers to the Medicare Learning Network from the Centers for Medicare & Medicaid Services (CMS) and the Medi-Cal Learning Portal from the Department of Health Care Services (DHCS).

For additional information regarding billing time limits and corrected claims, please refer to the Provider Manual. Call Provider Services for additional help at **1-408-874-1788**, Monday through Friday, 8:30 a.m. to 5:00 p.m. Check tracing and "reissues" are also handled by Provider Services in conjunction with Finance. Visit our website for additional resources on claims and disputes: www.scfhp.com/for-providers/submit-a-claim-or-dispute/.

Claims processing and payments

- Facilities must submit claims using a UB-04 form, which must be submitted through Electronic Data Interchange (EDI). A facility may submit claims as frequently as desired.
- A hardcopy EOB is not required for Medicare coordination of payment.
- Be sure that claims have all data elements completed to ensure timely payment.
- To be processed, include a valid authorization number, which must also match the member's line of business and dates of service.
- Be sure to submit your claims with the correct revenue code to match the authorization type. For example, mismatching a long-term authorization with a skilled revenue code will result in a claims denial for a mismatched authorization. Please refer to your contract if you have questions.
    - Long-term care authorizations must be submitted with long-term care claims.
    - Skilled authorization must be submitted with skilled services claims.

AB1629 rate updates

For annual AB1629 rate updates, SCFHP automatically makes the necessary rate and fee schedule updates within 7-10 days of the rate release on the Department of Health Care Services (DHCS) website. SCFHP uses the approved fee schedules to update our claims processing system. It is up to each billing entity to bill at the current or interim rate. On an annual basis, specific claims previously paid at a lower rate will be automatically reprocessed for retroactive rate adjustments. No action is needed by the provider or biller to initiate the retroactive claims process. Any new claims submitted with the new rate will be processed at the new rate. Claims processed at a lower rate are adjusted by the claim overpayment process

Billing matrix

The SNF Billing Matrix on the LTSS page is an excellent resource for billers who need a quick reference for SCFHP claims billing. Please note the following tips:

- When submitting a claim, please be sure to include all required data elements to assure timely payment. For processing, an authorization number must be included on the claim form. The claim must match the authorization.
- If you are a biller and received a denial for no authorization on file, your facility may need to submit a retroactive (retro) Prior Authorization Request. At times, members can change lines of businesses, so be sure to submit Cal MediConnect and Medi-Cal requests respectively.
- Overpayment letters require a 30-day response for returning checks. Therefore, we recommend each facility develop a process for forwarding overpayment letters to your biller(s), especially if staff work at a different location than the facility.
    - If no action is taken, SCFHP Claims will apply the overpayment (credit) to a future check.
- Use valid value, discharge, and revenue codes at all times.
- Avoid using Discharge Code 00 (invalid code) or the claim will be denied.
- To submit a corrected claim, submit the claim electronically using x217. Verify the corrected claim was received on Provider Link.

Share of cost claims

Most Medi-Cal beneficiaries do not have share of cost. However, if a member has a Share of Cost (SOC), the amount is generally based on their income level and Medi-Cal eligibility requirements. When identified, these members must meet their specified SOC. Beneficiaries may also use their SOC to pay for necessary, non-covered medical services or items not covered under Medi-Cal.

It is the responsibility of each facility to collect the Share of Cost (SOC) and subtract this obligatory amount from the billed amount. In addition, the facility must “clear” the member SOC on the Medi-Cal website each time a SOC is collected through the following steps:

1. Sign in to the Medi-Cal AEVS website’s eligibility link, then click on SOC spend down.
2. Enter the member’s information, then submit the share of cost.
3. The website will generate a report indicating that the SOC has been “cleared.”

When a Medi-Cal beneficiary has an LTC Aid Code and an SOC, the facility will collect the amount and SCFHP will pay the balance. Please submit Share of Cost claims with Value Code 23. In addition, follow Medi-Cal guidelines for submitting SOC by entering prior payments and amount due in Boxes 54 and 55, respectively.

Section 5 - Nursing facility responsibilities

Census and notification requirements

SCFHP requires timely and accurate updates from each facility about our members. Timely notification of change in status or level of care is required to ensure that SCFHP has an accurate updated census count. If any of the following conditions apply, it is each facility's responsibility to notify and communicate with SCFHP within 24 hours. Please include the required discharge summary. The conditions are as follows:

1. If a member is admitted into hospice care, complete the Long-Term Care Discharge Notification Form.
2. If members relocate due to a natural disaster, fire, or other similar events, initial notification may be done by telephone, secure email, or by fax.
3. If members involuntarily discharge for non-payment of charges, clinical needs,clinical compliance, or behavioral issues.

Please notify SCFHP of:

- All member admissions (Hospital, SNF, ICF, Subacute, Pediatric Subacute).
    - Do not wait to admit a member solely based on the reason that SCFHP is closed and prior authorization was not yet obtained.
- Bed hold authorizations
    - SCFHP follows Medi-Cal's guidelines for bed hold and Leave of Absence (LOA).
    - Fax a Bed Hold Authorization Request Form upon completion of bed hold to **1-408-874-1957**.
    - Bed hold requests are required for notification and billing/payment purposes.
- An adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization or an emergency department visit.
    - A facility may modify its care of a member or discharge them if the facility determines that the following specified circumstances are present:
        - The facility is no longer capable of meeting the member's health care needs;
        - The member's health has improved sufficiently so that they no longer need nursing facility service; or
        - The member poses a risk to the health and safety of other individuals in the facility.
    - SCFHP will assist with the discharge if there is a need. Otherwise, the facility is responsible for ensuring a safe discharge through proper discharge coordination.
- Long-term care discharge notification
    - Long-term care discharges include hospice, discharge to the community, home, or death. For additional information on long-term care discharges, please refer to our frequently asked questions on the LTSS page.
    - Fax a completed Long-term Care Discharge Notification Form within 24 hours of discharge to **1-408-874-1957**. In addition, fax the required MC-171 form to SCFHP when it is submitted to DHCS.

Care coordination & discharge planning

Facility responsibilities include:

- Notify and invite the assigned SCFHP case manager to provide input for the development of the member's care plan, including participation in the interdisciplinary care team meetings.
- Coordinate with SCFHP to plan discharge and transition from the nursing facility. The facility is encouraged to reach out to SCFHP for support for complex cases.
- Complete Interdisciplinary Care team (ICT) training on SCFHP website.
- Provide access to the facility, nursing facility staff, and the member's medical information and records.
- Provide minimum data set (MDS) information or pages as required.

Please refer to Section 7 Case Management and Care Transitions for more detailed information.

Access to records and information

The facility will provide Santa Clara Family Health Plan representatives access to the facility for utilization management, care coordination, member services, and general provider services activities. The facility will provide reasonable notice of and opportunity to participate in care planning discussions and activities with SCFHP. SCFHP expects reasonable access to the member medical records. Access includes the ability to view electronic health records as well as traditional paper records.

The facility must comply with timelines, definitions, formats, and instructions specified by SCFHP. Upon the receipt of record review request from SCFHP, regulatory or program integrity functions, the facility must provide—at no cost to the requesting agency— the records requested within three business days.

Documents related to a record review include diagnosis, treatment, lab results, charting, and doctor's orders. For other review reasons, SCFHP may also request billing records, claims, invoices, documentation of delivered items (equipment or supplies), and any business or accounting records or reports with support documentation. If a financial or quality audit is required, support documentation, computer records/data, as well as contracts with other providers or vendors may be requested.

Reporting abuse, neglect or exploitation

Providers are required to:

- Report abuse, neglect, and exploitation.
- Inform members on how to report abuse, neglect, and exploitation.
- Train staff on how to recognize and report abuse, neglect, and exploitation.

Section 6 - Long-term services and supports

Managed LTSS Medi-Cal benefits and community resources enable safe and timely transitions of members from nursing facilities back to the community and help to prevent readmissions. These include health, health-related, and non-medical social services that support independent living and address the support for daily living activities. The SCFHP LTSS team can assist with accessing these benefits and additional home and community-based resources.

Long-term services and supports (LTSS)

Medi-Cal LTSS benefits managed by the health plan include the following:

- Community-based adult services (CBAS)
- Multipurpose senior services program (MSSP)
- Long-term care in a nursing facility, including skilled, subacute, and long-term custodial care

In-Home Support Services (IHSS) is a Medi-Cal LTSS benefit administered by the Santa Clara County Social Services Agency. The SCFHP LTSS team can help facilitate timely submissions and responses to applications for new services or reassessments.

For more information on IHSS and training modules, visit the Long-Term Services and Supports page.

Section 7 - Case management and care transitions

SCFHP and provider coordination

SCFHP's case management program is designed to identify potential clinical problems and social needs impacting health, especially those of a chronic or complex nature. Case management is a collaborative process of evaluation, planning, facilitation, and advocacy for members whose health conditions warrant particular attention. Members, their families, or authorized representatives, including the PCP and provider staff, are key to the success of a care plan and resulting health outcomes. Case management can also facilitate authorizations of all needed benefits and services.

SCFHP Case Management team works in close communication with the facility social service and clinical staff and the physician to ensure our members are at the appropriate level of care and have timely access to covered benefits, carved out services, and connections to resources that support safe transitions. SCFHP has designated case managers and personal care coordinators assigned to LTC members and specialty mental health (SMI).

Health Risk Assessment & Individual Care Plan

A Health Risk Assessment (HRA) and individual care plan (ICP) must be completed for Medi-Cal and full-scope Medi-Cal members upon initial enrollment to SCFHP and annually. A reassessment is also required following a member's change of condition, or in anticipation of a transition or change in level of care.

The HRA is a state-approved comprehensive assessment tool that evaluates the member's medical, psycho-social, and functional status. The HRA is conducted by the case manager with the member or the authorized representative via telephone or in-person. Additional clinical information will be requested from the SNF such as MDS, lab data, vital signs, care plan, physician order summary, and other clinical information. This information is used along with the HRA and input from members of the Interdisciplinary Care Team (ICT) to establish the member's Individual Care Plan (ICP).

Certain members may require more frequent contact with case management to ensure continuity of care. Members in transition or who have frequent readmissions to acute settings may require additional contact and coordination of services.

Members whose primary coverage is with Medicare fee-for-service or other insurance do not require HRAs. Typically, this group includes members who have opted out of or were not eligible for SCFHP Cal MediConnect. SCFHP is required to review the nursing facility's assessment and care plans for these members to determine if any further coordination of services is appropriate. The Long-Term Care (LTC) Case Manager also supports facilities in getting the IHAs completed for members.

Once the HRA is complete, the case manager may choose to conduct additional visits with the member or to contact the SNF to request additional clinical information pertaining to the member's plan of care or discharge plan.

Interdisciplinary Care Team (ICT) - Provider Training

Each member is entitled to an ICT that supports the development and implementation of their care plan. The case manager and physician are required members of the ICT. The ICT may also include the member, the authorized representative, and any other key stakeholders in the care plan or providers, with the member's permission.

To participate in the ICT, SNF staff must complete the required Core Competencies Training on our website. Completion and signed attestations are required upon hire and thereafter on an annual basis for staff involved. For questions related to LTSS ICT Core Competencies Training, please contact LTSSHelpDesk@scfhp.com.

For questions related to case management for LTC members, please contact the member's assigned case manager. All requests should include the member's name, date of birth, and SCFHP member ID number sent in a secure email. All LTC members receiving case management will have an assigned case manager who is the point of contact for SNF staff.

Case management and long-term care transitions

California State initiatives require that SCFHP assess member's willingness and ability to transition from nursing facilities back to the community as appropriate. SCFHP has designated case managers to work closely with nursing facility staff to support transitions for members in LTC. This includes providing education and connection to LTSS benefits and other supportive services to enable safe and timely transitions.

For more information about working with SCFHP on transitions, please refer to our Safe Discharges Training and Pre-Discharge Checklist.

Successful case management and care transitions require collaboration and timely notifications between the SCFHP case manager, SNF staff, and others involved in the member's care. Please use secure email to contact the LTC Case Manager when a member has a change of condition, including:

- Emergency Room (ER)/Department (ED) visit
- Discharge planning
- Transfer to another care setting
- Transition to another level of care, including hospice
- Death

Care coordination and behavioral health

For members with a behavioral health diagnosis, a Psychiatrist may be required to visit the member in the skilled nursing facility for visits related to pharmacy prescriptions or counseling and assessment reasons. When behavioral health care needs are identified, please refer to an appropriate behavioral health provider to ensure that the member receives timely access to appropriate levels of medical care for behavioral illness, substance abuse, and the management of psychiatric medications.

Section 8 - PCP responsibilities

Primary Care Providers (PCPs) are an essential factor in overall member care.

The following is important information for PCPs, medical directors, and specialists serving SCFHP members in a Long-Term Care/Skilled Nursing Facility.

You can help us provide seamless care to your patients (our members) by ensuring you:

- Submit requests for prior authorization (PA).
- Sign written orders including:
    - Required assessment or authorization documents for Managed Long-term Services and Supports benefits (e.g., CBAS). A signature is required.
    - Required orders for home health services, hospice, therapy or durable medical equipment/services for discharge planning. A signature is required.
- Establish ongoing orders for medically necessary services and/or consultations (e.g., diabetic foot checks, cardiac services, psychiatry consult for medication management).
- Refer to in-network specialists as needed for member care, including but not limited to SNF podiatrists and psychiatrists.
- Participate in member care meetings as needed to communicate with SCFHP CM and the member's Interdisciplinary Care Team (ICT) for optimal coordination and care transitions.
- Communicate discharge plans with the facility. This includes orders, medication reconciliation, referrals to specialty doctors, or any other components that are vital to the member's successful transition.
- Know the training requirements. The SCFHP website has a Provider Resources page that includes communications, resources, and required training for providers. You may be asked to complete a training program to meet a regulatory requirement.
- Complete Physician Orders for Life-Sustaining Treatment (POLST) as well as advance directives for all SCFHP members in SNFs. Include these documents in the member's chart. Additionally, "Do Not Transfer" orders should be clearly stated and visible in the member's chart, along with any additional information regarding hospital transfers for life-sustaining or resuscitative services.

Section 9 - Quality management

SCFHP has a comprehensive quality assurance program, auditing and reviewing contracted providers upon its discretion. Providers have the responsibility to report any fraud, waste, or abuse.

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and services for its members. The QIP assists SCFHP in achieving these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies.

Please refer to the Quality Improvement Program page for more information.

Role of Long-Term Services and Supports (LTSS) team in quality

The LTSS team actively monitors quality and performance measures for contracted facilities, and works closely with nursing facility staff to identify opportunities for improvement or additional education as needed. Outreach is provided to facilities to foster partnerships on quality improvement initiatives. We review CMS (Care Compare) data and operations quality information such as:

- Timely submission of long-term care discharge notifications (within 24 hours of discharge)
- Hospital readmissions
- Pressure ulcers
- Urinary tract infections (UTI)
- Flu and pneumococcal vaccine administration
- Infection control
- Completion of member-specific documents such as Physician Orders for Life-Sustaining Treatment (POLST) or advanced directives
- Falls with major injury
- Preventable (potentially avoidable) readmissions to the hospital
    - Examples of causes among nursing home residents include:
        - Pneumonia
        - Urinary tract infections (UTI)
        - Congestive heart failure
        - Dehydration

Admission date quality monitoring for long-term care members

For quality and operation reasons, SCFHP actively monitors admission dates submitted on the Long-Term Care Authorization Request Form. On an ongoing basis, please ensure the accuracy of the admission date on each authorization request. The examples below describe the admission date use requirements.

Admission Date	Scenario/Description	Admission Date Rule
New skilled admission to SNF	New admission	Please use the current admission date to SNF without any discharge to a lower level of care—such as community or hospice.
SNF to home SNF to hospice	If a member previously discharged to home or hospice, then came back to the facility, use the admission date of current stay to the SNF.	Please use the current admission date.
SNF to hospital, then hospital to SNF	If a member went from SNF to hospital and then came back to SNF	Please use the current admission date*. *There would not be a new admission date because the member did not go to a lower level of care. The current stay admission date would be the date the member admitted to the SNF prior to going to the hospital—even if the member exceeded a bed hold.
SNF to hospital, then hospital to home	If a member readmits to the SNF from home, use the new admission date for current stay.	Please use the new current admission date when member readmits from home.

Additional Resources List

The documents and forms below are available on www.scfhp.com.

The Long-Term Services and Supports (LTSS) page contains:

- What is Managed LTSS?
- SNF PCPs and Medical Director's Provider Responsibilities
- Billing Guidelines for Medi-Cal and Cal MediConnect Claims
- Nursing Facility Pre-Discharge Checklist
- Long-term Care Quick Reference Guide
- Long-term Care Authorization Request Form & FAQs
- Long-term Care Discharge Notification Form & FAQs
- Bed Hold Authorization Request Form & FAQs
- LTSS Training
- Quality tools for monitoring members and preventing unnecessary readmissions to a hospital

The Provider Resources Training page contains:

- Cultural Competency Toolkit
- LTSS Training
- Provider Manuals (Medi-Cal and Cal MediConnect)
- Interdisciplinary Care Team (ICT) Overview and Core Competencies
- Provider Orientation
- Provider Packet
- Provider Portal 101

For more documents and forms, visit www.scfhp.com/for-providers/forms/.