Policy Title: Discharge Planning		POLICY #: 10.2.33 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 12/97	**Effective Date** 11/22	**Revision Date** 12/18, 9/21, 10/22
VP Approval: Tracy Alvarez, VP, Medical Care Solutions			**Date of Approval:** 2/17/2023
Medical Services/P&T Committee: (If Applicable) PHP CMO			**Date of Committee Review:** 2/9/2023

A. PURPOSE

To define the policy and procedure and provide guidance on how Blue Shield Promise Health Plan (BSCPHP) will use to identify, evaluate, coordinate, and implement discharge planning needs by the Utilization Management (UM) Department for BSCPHP Members when hospitalized. All UM activities are performed in accordance with H&S Code §1363.5 and §1367.01 and 28 CCR §1300.70(b)(2)(H) and (c).

B. DEFINITIONS

1. "Concurrent Review" is the review for members currently in an acute or post-acute setting. The three components of this member centric review: 1) medical necessity review; 2) discharge and transitional care planning; and 3) coordination of care. Utilization Management's focus during acute hospital stay is for a smooth transition across the continuum of the member's stay.

2. "Discharge Planning" begins at time of admission to ensure that necessary services and supports are in place in the community before the individual leaves the hospital or institution in order to reduce re-admission risks, improve member and family participation, enhance member satisfaction, assure post-discharge follow-up, increase medication safety, and to support a safe transition.

3. "Medical Necessity" is the term medically necessary will include all covered services that are reasonable and necessary to protect the life, prevent illness or disability, alleviate sever pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR §51303(a) and 42 CFR §438.210(a)(5).

    a. When determining the medical necessity of covered services for Medi-Cal beneficiary under the age of 21, medical necessity is expanded to include the standards set forth in 42 USC §1396d(r) and W&I Code §14132.

b. For individuals under age 21, EPSDT service is considered medically necessary when it is necessary to correct defects and physical and mental illnesses and conditions that are discovered by screening services.

C. POLICY

I. The BSCPHP Utilization Management (UM) team will perform concurrent review on for all scheduled and non-scheduled inpatient admissions. The review process includes chart review, data collection, review of care plan with the attending physician and other members of the healthcare team, as well as discharge planning.

II. Discharge planning will begin on the day of admission for inpatient stays. For elective inpatient stays, these needs may be identified prior to the hospitalization and coordinated through the Prior Authorization process. The UM team will follow members through the continuum of levels of care until the member is returned to his/her previous living condition prior to hospitalization when possible.

a. Discharge planning includes:

i. Evidence of an evaluation by discharge planning/social services note should be on the patient's chart within 24 hours. If not, a call will be placed requesting it.
ii. Identification of discharge needs
iii. Identification of the needs short term or long term
iv. Validation that patient needs have been clearly communicated to all involved parties (physician, family members, direct care givers)
v. Determination of status patient are they going home, is there a need for home safety check
vi. Need for additional resources (linked services, delivery of meals, transportation to physician appointments)
vii. Need for necessary DME supplies home health care and follow up appointments will be made prior to the patient leaving the hospital.
viii. Transportation and placement arrangements will be made utilizing contracted providers.
ix. If the Primary Care Physician (PCP) was not the attending physician of the patient while hospitalized, all effects will be made to notify him/her of any arrangements made for the patient. This may be done by one of the following mechanisms:
x. Dictated hospital summary note from the attending physician
xi. Phone call from the attending

D. PROCEDURE

I. When notified of discharge, utilization management nurse will ensure that all medically necessary covered services are provided in a timely manner upon discharge; ensure that all prior authorizations required for member's discharge are processed within timeframes consistent with the urgency of the member's condition (not to exceed five working days for routine authorizations or 72 hours for expedited authorizations; that the members transition to the most appropriate level of care and community based care occurs, from the facility best meets the members medical and social need; and it is mutually agreed upon with member's provider and BSCPHP. See UM policy 10.2.38 Prior Authorization for additional information.

a. During the Discharge Summary process, BSCPHP will do the following:
    i. Implement a standardized discharge risk assessment that is to be completed prior to discharge to assess a Member's risk of re-institutionalization, re-hospitalization, and risk of mental health and/or Substance Use Disorder (SUD) relapse;
    ii. Obtain permission from Members, Members' parents, legal guardians, or authorized representatives, as appropriate, to share information with Providers to facilitate transitions, in accordance with federal and state privacy laws and regulations;
    iii. Ensure that medication reconciliation is conducted pre- and post-transition;
    iv. Ensure Closed Loop Referrals to Community Supports and coordination with county social service agencies and waiver agencies for IHSS and other HCBS;
    v. Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five Working Days for routine authorizations, or 72 hours for expedited authorizations. This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which BSCPHP is responsible, and DME that are processed in accordance with 42 CFR §438.210, H&S Code §1367.01;
    vi. Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization;
    vii. Ensure that mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services exist between BSCPHP and each of its Network Provider and Out-of-Network Provider hospitals within its Service Area;
    viii. Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, BSCPHP's authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;
    ix. Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs; and
    x. Ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge.

II. Discharge Planning and Care Coordination

a. BSCPHP will provide a Discharge Planning document to Members, Member's parents, legal guardians, or authorized representatives, as appropriate, when being discharged from a hospital, institution, or facility. Discharge Planning document will include the following information, at a minimum:

    i. Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;

ii. Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;
iii. The hospital, institution, or facility to which the Member was admitted;
iv. Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;
v. Summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or authorized representatives in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution, or facility to be included in the Member's Medical Record; and
vi. Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution, or facility, including the scheduled outpatient appointment or follow-up with the Member.
vii. The care manager's name and contact information, and a description of the transitional care services in language that is culturally, linguistically, and literacy-level appropriate.

III. Nursing Facility Transitions

a. When transitioning Members to and from Skilled Nursing Facilities, BSCPHP will ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

i. Coordinate with facility discharge planners, care or case managers, or social workers to provide case management and Transitional Care Services during all transitions;
ii. Assist Members being discharged or Members' parents, legal guardians, or authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS;
iii. Maintain contractual requirements for Skilled Nursing Facilities to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;
iv. Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;
v. Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and
vi. 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 requirements.

E. MONITORING: N/A

F. REPORTING: N/A

G. REFERENCES & ATTACHMENTS:

1. 28 CCR §1300.70(b)(2)(H) and (c)
2. 42 CFR §438.210
3. H&S Code §1363.5 and §1367.01
4. P&P 10.2.38 Prior Authorization
5. W&I Code §14132

H. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-Filing Number
2/2023	Updated Regulatory Requirements DHCS	