blue california
Promise Health Plan

Policy Title: Care Transitions When Benefits End		POLICY #: 10.2.42 Line of business: MCAL	
Department Name: Utilization Management	**Original Date** 1/99	**Effective Date** 5/19	**Revision Date** 12/18. 9/22
Department Head: Sr. Director, UM		**Date: 10/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 10/22**	

PURPOSE

To outline the process of how Blue Shield of California Promise (Blue Shield Promise) will identify members and assist them with coordination of care when their benefits or insurance coverage is scheduled to end and they still require continued care.

POLICY

An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. Treatment Record Review (TRR) providers only apply to behavioral health.

Discontinuing an active course of treatment resulting from the exhaustion or termination of a benefit or health coverage could cause a recurrence or worsening of the member's condition under treatment and interfere with anticipated outcomes. Blue Shield Promise Health Plan will act to ensure continuity of care, despite discontinuation of benefits or disenrollment from continued coverage for any member receiving an active course of treatment for an acute episode, or long term or chronic illness.

PROCEDURE

1. When the member's coverage of services is scheduled to end while a member still needs care, Blue Shield Promise Health Plan shall offer to educate and assist the member (or the member's designated representative) in how to access alternatives for coming care in order to obtain care as appropriate.
    a. 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.
2. Members whose benefits will end, but who will still need care, are identified from case manager reports, through the authorization referral process, provider notifications, member inquiries, and/or other processes such as reviewing member eligibility requirements for Linked and Carved-out Services.

a. 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

3. Benefits ending may include, but are not limited to the following:
    a. Benefits ending due to benefit limitations, specific to the Member's Evidence of Coverage
    b. Physical or occupational therapy
    c. Behavioral Health Services
    d. Durable Medical Equipment
    e. Home Health
    f. Acute Rehabilitation Services
    g. Long Term Care
    h. Members reaching age 21 who are receiving CCS or other Linked and Carved-out Services that have age specific requirements
    i. Adolescents that reach age of 18 and need to transition from a pediatrician to the care of a GP. IM, or Family Practice practitioner
    j. Benefits ending due to member eligibility, voluntary or involuntary disenrollment
4. Blue Shield Promise will assist with a patient's transition of care, if necessary, when benefits end for those patients who are receiving approved services while still in need of medically necessary care by offering the following assistance:
    a. Implement a standardized discharge risk assessment that is to be completed prior to discharge, to be approved by DHCS, to assess a Member's risk of re-institutionalization, re-hospitalization, and risk of mental health and/or SUD relapse.
    b. Ensure that medication reconciliation is conducted pre- and post-transition (See Case Management for Post-Transition).
    c. Ensure Closed Loop Referrals to Community Supports and coordination with county social service agencies and waiver agencies for IHSS and other HCBS.
    d. Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization
    e. Ensure that mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services exist between Contractor and each of its Network Provider and Out-of-Network Provider hospitals within its Service Area.
    f. Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur.
    g. 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.
    h. Ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge.
    i. Care Management will identify available resources in the local community for patients when benefits end.
    j. Care Management will discuss and educate patients on alternative care and resources available.
    k. Utilization Management will provide notification of alternative resources within the denial notification
5. The Blue Shield Promise Case Management Department will request the help of Social Services to assist as needed

a. The Social Services Department maintains a current list of community agencies and resources to help beneficiaries;
    i. Examples include Rainbow Directory of resources
    ii. Community based agencies by
        1. Agency type
        2. Geographical location
        3. Cultural and linguistic capabilities

REFERENCES