blue california

Promise Health Plan
3840 Kilroy Airport Way
Long Beach, CA 90806

January 24, 2024

Subject: **Notification of required regulatory updates and April 2024 updates to the *Blue Shield Promise Health Plan Nursing Facilities Reference Guide***

Dear Provider:

Blue Shield Promise is revising the *Blue Shield Promise Health Plan Nursing Facilities Reference Guide* (Reference Guide). The changes in each provider manual section listed below are described either as a regulatory update, not subject to negotiation and effective January 31, 2024, or as a notice of an update effective April 1, 2024.

All updates included in this letter will appear in the April 2024 version of the *Blue Shield Promise Health Plan Nursing Facilities Reference Guide* posted by January 31, 2024 on the Blue Shield Promise Provider website at www.blueshieldca.com/en/bsp/providers in the *Provider manuals* section under *policies & guidelines* .

You may also request a PDF version of the revised *Blue Shield Promise Health Plan Nursing Facilities Reference Guide* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *Blue Shield Promise Health Plan Nursing Facilities Reference Guide* is included by reference in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medi-Cal providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Nursing Facilities Reference Guide* and the agreement held by the provider and Blue Shield Promise, the agreement prevails.

If you have any questions regarding this notice or about the revisions that will be published in the April 2024 version of this Reference Guide, please contact Blue Shield Promise Provider Customer Services at (800) 468-9935 [TTY 711] 6 a.m. to 6:30 p.m., Monday through Friday.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

Added the following new section in support of the CalAIM Initiative:

Transitional Care Services (TCS)

The goal of Transitional Care Services (TCS) is to ensure that Blue Shield Promise members receive the highest-level of care from the time of admission to post discharge until they have been successfully connected to all needed services and supports. The following requirements are referenced from the DHCS CalAIM: Population Health Management (PHM) Policy Guide and build upon existing facility requirements. These requirements are meant to ensure coordination of care, continuity of care, and optimum outcomes for Plan members in their care transitions. Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

Admission, Discharge, and Transfer (ADT) Data

In accordance with CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and the CalHHS Data Exchange Framework (DxF), general acute care hospitals and emergency departments, as defined by California's Health & Safety Code §1250, (together "Participating Facilities"), must send admission, discharge, or transfer (ADT) notifications to other organizations that have signed the DxF Data Sharing Agreement if requested in advance of the admission, discharge, or transfer event (ADT Event).

Participating Facilities are required to send notification of ADT Events unless prohibited by applicable law. They must also accept notification of ADT Events from any other participant and send notification of ADT Events as requested using a HIPAA-compliant method and in a format acceptable and supported by the requesting participant. These DxF requirements will support Blue Shield Promise capabilities to receive ADT notifications from a variety of Participating Facilities.

Requirements for High- vs. Lower-Risk Transitioning Members

Minimum TCS requirements vary for high-risk and lower-risk transitioning members as described below. "High-risk" transitioning members means all members listed in the DHCS PHM Policy Guide as:

- Those with Long-Term Services and Supports (LTSS) needs;
- Those in or entering Complex Care Management (CCM) or Enhanced Care Management (ECM);
- Children with special health care needs (CSHCN);
- Pregnant individuals: for the purposes of TCS, "pregnant individuals" includes individuals hospitalized during pregnancy, admitted during the 12-month period postpartum, and discharges related to the delivery; and
- Seniors and persons with disabilities who meet the definitions of "high-risk" established in existing DHCS APL 22-024.

- Other members assessed as high-risk by Risk Stratification Segmentation and Tiering (RSST).

In addition to these groups, discharging facilities must also consider the following members "high-risk" for the purposes of TCS:

- Any member who has been served by county Specialty Mental Health Services (SMHS) and/or Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by Blue Shield Promise or discharging facility;
- Any member transitioning to or from a SNF; and
- Any member that is identified as high-risk by the discharging facility and thus is referred to or recommended by the facility for high-risk TCS.

Notifying a Care Manager

I. High-Risk Members

Once a member has been identified as being admitted as high-risk, Blue Shield Promise will assign a Care Manager responsible for TCS, who is the single point of contact responsible for ensuring completion of TCS requirements across all settings and delivery systems.

Members may choose to have limited or no contact with the care manager. In these cases, the discharging facilities must, at minimum, comply with federal and state discharge planning requirements listed below and assist in care coordination with the Care Manager, the Primary Care Provider (PCP), and any other identified follow-up providers.

For high-risk members in transition, their assigned Care Managers (including ECM and CCM) must be notified within 24 hours of admission, transfer, or discharge when an ADT feed is available, or within 24 hours of Blue Shield Promise being aware of any planned admissions, or of any admissions, discharges, or transfers for instances where no ADT feed exists (such as for SNF admissions). However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

II. Lower-Risk Members

Blue Shield Promise will provide a dedicated TCS team available to lower-risk members in transition that is available via phone at (877) 702-5566 from 8 a.m. to 5 p.m. Monday through Friday.

The discharging facility must incorporate the Blue Shield Promise TCS phone number (877) 702-5566 into the discharge documents for lower-risk members. Lower-risk members will have access to the dedicated TCS team for at least 30 days from discharge.

Discharge Risk Assessment and Discharge Planning

Discharge planning is required for all members experiencing a care transition. Hospitals must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements; and certain similar requirements apply to SNFs.

At the time of the member's discharge, all necessary services that require a prior authorization are processed within the time frames outlined below. For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process. All prior authorizations required for the member's post-discharge services are processed within time frames consistent with the urgency of the member's condition, not to exceed five (5) working days for routine authorizations, or 72 hours for expedited authorizations. The discharge planning requirements below should be considered when transfers occur between discharging facilities (general acute care hospital, long-term acute care, and skilled nursing facilities).

All discharging facilities must carry out a discharge planning process that includes the elements outlined below.

- Engages members, and/or members' parents, legal guardians, or Authorized Representative, as appropriate, when being discharged from a hospital, institution, or facility.
- Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
- Ensures each member is evaluated for all care settings appropriate to the member's condition, needs, preferences, and circumstances.
- Members are not to be discharged to a setting that does not meet their medical and/or mental health needs.
- A consistent discharge risk assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with discharging facilities' current processes.
    - For high-risk members, discharging facility must share this information with Blue Shield Promise assigned care manager and have processes in place to screen and refer members to longer-term Care Management programs (ECM or CCM) and/or Community Supports, as needed.
    - For members not already classified as high-risk by Blue Shield Promise per above definitions, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to Blue Shield Promise for:
        - Any member who has a specialty mental health need or substance use disorder.
        - Any member who is eligible for an ECM Population of Focus.
        - Any member whom the clinical team feels is high-risk and may benefit from more intensive transitional care support upon discharge.
- Ensures that discharging facilities share discharge instructions/summaries with a Blue Shield Promise assigned Care Manager and Member's PCP in a timely manner.
- The Care Manager will work with discharging facilities to ensure the Care Manager's name and contact number is included in key discharge documents. The state mandates that Blue Shield Promise follow-up with:
    - High-risk members within **7 days** post discharge
    - Lower-risk members within **30 days** post discharge

- Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with discharging facilities' current requirements.
- Notifies post-discharge providers and share clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
- Sends a discharge notification letter to the Primary Care Physician of record within 24 hours of discharge.
- Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.
- Discharge summaries and medication lists must be shared with the Blue Shield Promise Care Manager, the member, the member's caregivers, PCP, and treating providers.
    - This must include a pre-discharge medication reconciliation completed upon discharge that includes education and counseling about the member's medications.
    - A second medication reconciliation must be completed after discharge once the member is in their new setting (post-discharge) and this can be completed by a follow-up provider, such as the PCP, care manager, or another provider with the appropriate license.

Oversight and Monitoring

Blue Shield Promise is accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements. For managing care transitions, Discharging facilities (general acute care hospitals, long-term acute care hospitals, and skilled nursing facilities) must follow all applicable Code of Federal Regulations, California state laws, Joint Commission requirements, and relevant Blue Shield Promise policies and procedures (e.g., Discharge Planning Policy and Managing Care Transitions Policy).

The hospital/discharging facility's responsibility to perform discharge planning does not supplant the need for TCS. Discharging facilities are required to have their own published policies and procedures that account for the above requirements and those noted in the DHCS PHM Policy Guide to support effective care transitions. Blue Shield Promise will conduct routine oversight and monitoring activities to ensure compliance with DHCS requirements and that key protocols are being followed to provide the highest level of care and services to our members.

Added the following section to comply with AB 133 which mandates the creation of the California Health and Human Services Data Exchange Framework for Medi-Cal providers. This update is effective 1/31/24:

Health Information Data and Record Sharing with Blue Shield Promise

Providers shall comply with State requirements regarding electronic health record data exchange, including without limitation those outlined in the California Health and Human Services Data Exchange Framework, and the compliance milestones established for Calendar Year 2022-2024 and other program policy and procedure requirements, and additional state and federal regulations as applicable, and as updated and amended from time to time. Such program requirements and State law, implementing regulations and regulatory guidance shall govern the sharing of electronic health record data beginning January 31, 2024. Blue Shield Promise is able to receive electronic health record data through the following platforms: (i) EPIC Payer platform, (ii) Manifest MedEx platform, and (iii) State Qualifying Health Data Exchange platform. Providers shall participate in and utilize one of the aforementioned options in providing electronic health record data to Blue Shield Promise within the timelines set forth in the State requirements as they may be amended from time to time. For informational purposes, as of January 1, the required timelines include:

On or before January 31, 2024, unless otherwise stated:

- General acute care hospitals, as defined by Section 1250. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Provider and physician organizations and medical groups. as defined by Section 127500.2. (Fewer than 25 physicians, and nonprofit clinics with fewer than 10 providers, the compliance date is 1/31/26.)
- Skilled nursing facilities, as defined by Section 1250, that currently maintain electronic records. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Clinical laboratories, as that term is used in Section 1265 of the Business and Professions Code, and that are regulated by the State Department of Public Health.
- Acute psychiatric hospitals, as defined by Section 1250. (Fewer than 100 beds and state-run acute psychiatric hospitals, the compliance date is 1/31/26.)
- Emergency medical services, as defined by Section 1797.72.