| **Section (Primary Department)**<br>**Medical Management** | | **SUBJECT (Document Title)**<br>**Continued Stay Review/Care Coordination/ Discharge Planning - CA** | |
|---|---|---|---|
| **Effective Date**<br>12/01/1995 | **Date of Last Review**<br>02/06/2024 | **Date of Last Revision**<br>02/06/2024 | **Dept. Approval Date**<br>02/06/2024 |
| **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 Medicaid (Anthem) is committed to members receiving medically appropriate care and services. The care and services must meet standards for quality and be provided at the appropriate level.

Anthem conducts Continued Stay Review, Care Coordination, and Discharge Planning for all inpatient admissions that extend beyond the originally requested and approved length of stay to determine medical appropriateness and ensure member services provided are at the appropriate level of care. Anthem provides the facility's Utilization Review (UR) Department assistance with discharge planning within one (1) business day of request.

For members who experience a care transition, Anthem will ensure that members are supported from discharge planning until they have been successfully connected to all needed services and supports. Anthem will provide timely prior authorizations for all members and will know when members are admitted, discharged or transferred.

Only qualified licensed and clinically experienced associates perform clinical reviews. The Utilization Management (UM)/Care Management (CM) Registered Nurse (RN) determines the medical necessity of an inpatient admission and continued stay utilizing Anthem Medicaid approved screening criteria, medical policy guidelines, and MCG™.

Only a licensed Physician Peer Clinical Reviewer (PCR) with sufficient expertise to evaluate the specific clinical issues involved in the health care service(s) requested by the provider can deny requested services.

When there is a denial of continuing services during a continued stay review, Anthem ensures that the health care service(s) is/are not discontinued until the member's treating provider is

notified. Anthem collaborates with the treating provider to develop an alternative treatment plan that meets the medical needs of the patient.

**DEFINITIONS:**

**Care Coordination:** Care coordination refers to the activities that occur where an RN evaluates any ongoing care gaps and helps to improve the inpatient care a member receives. An example of this is working with the provider to ensure a member can get the evidence-based treatment required. This also includes facilitation of transfers to alternate levels of care if required.

**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, post-acute care facilities, or long-term care (LTC) settings.

**Continued Stay Review:** Process that provides a mechanism for validating the medical necessity of an admission to a facility (initial review), supports the identification of appropriate level of care for the member's condition, ensures the appropriateness of the length of stay, and identifies opportunities for utilizing alternative care settings and treatments.

**Discharge Planning:** Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve member and family preparation, enhance member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe care transitions.

**Medically Necessary:** Procedures, treatments, supplies, devices, equipment, facilities or medications (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician or other health care provider; and

- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

The determination of medical necessity is the standard for reviewing all covered services for Anthem members.

**Peer Clinical Reviewer (PCR):** Physician who is employed by or contracted with Anthem to carry out utilization review. The physician is board certified in his/her specialty; and has a valid license to practice medicine in the State of California.

**Post-service Request:** A request is received for coverage of an acute inpatient stay after the member's discharge.

**PROCEDURE:**

**I. Continued Stay Review/Care Coordination/Discharge Planning**

Note: For Transitional Care Discharge Planning details, see Section IV below.

A. Anthem's UM/CM Nurse conducts Continued Stay Review/Care Coordination/Discharge Planning when there is a non-authorized admission, or extension of an inpatient stay.
    1. For an admission without pre-authorization, the attending physician's office or the admitting facility, must inform the Anthem's UM Department within one (1) working day of the admission.
    2. At the time of the admission notification, the Anthem UM/CM staff provides the caller with the UM/CM RN contact name and phone number, and informs the caller of the risk for retrospective denial for lack of clinical information and possible California Children Services (CCS) eligible condition, if applicable.

B. Health Professional Review Process
    1. Health professionals complete the following steps:
        a. Assess the provided clinical information.
        b. Request additional information as needed.
        c. Review the case against approved clinical review criteria.

C. Anthem only collects information necessary to perform utilization review and only requires submission of the section(s) of the medical record necessary for each case reviewed.

D. Upon receipt of clinical information, the Anthem UM/CM RN reviews the medical information obtained, including but not limited to:
    1. Office and hospital records
    2. A history of the presenting problem
    3. A clinical exam
    4. Diagnostic testing results
    5. Treatment plans and progress notes
    6. Patient's psychosocial history
    7. Information on consultations with the treating practitioner
    8. Evaluations from other health care practitioners and providers
    9. Photographs
    10. Operative and pathological reports
    11. Rehabilitative evaluations
    12. A printed copy of criteria related to the request
    13. Information regarding benefits for services or procedures
    14. Information regarding the local delivery system
    15. Patient characteristics and information
    16. Information from responsible family members
    17. Current and related historical medical diagnoses
    18. Medical treatment needs
    19. Social/environmental factors
    20. The clinical reviewer will contact the treating physician, as necessary.

E. The UM/CM RN performs continued stay review at regular intervals, as appropriate for the severity of the medical condition, to validate the medical necessity of ongoing inpatient care. When appropriate, the Anthem UM/CM RN assists the facility UR staff with the member's (including infants in neonatal intensive care units, transfer to an alternative setting and/or level of care, and other discharge planning needs.

**II. Review of Medical Necessity**

A. For cases that meet medical necessity, the UM/CM RN approves the requested services upon establishing medical necessity.

B. For cases that do not meet medical necessity criteria, the RN sends/tasks the case to a PCR for further review. If the PCR determines the service(s) is/are medically necessary, the PCR notifies the Anthem UM/CM Department, who in turn, notifies the requesting provider of the approval and completes the case.

C. If the PCR determines that the services are **not** medically necessary, the PCR informs the nurse of the decision and sends/tasks the case to the nurse for completion. For continued stay reviews, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient. Refer to Policy and Procedure CA_UMXX_013 Non-authorization of Medical Services and CA Health and Safety Code 1367.01.

   (The PCR is available for discussion of a decision and may be contacted through the Medical Management Department.)

D. For cases where the clinical information is not sufficient to determine medical necessity, the provider is contacted with a request for clinical information necessary to determine medical necessity.
   1. At least one (1) attempt is made to contact the requesting provider to obtain the necessary clinical information.
   2. If no response is obtained within the specified timeframe, the RN tasks the case to a PCR for further review.
      a. If the PCR determines the services are medically necessary, the PCR notifies the Anthem UM/CM Department, who in turn notifies the requesting provider and completes the case.
      b. If the PCR determines that the clinical information is not sufficient to determine medical necessity, the Anthem UM/CM Department notifies the provider of the decision to deny based on the information we have received.

E. Refer to Policy and Procedure CA_UMXX_117 for decision and notification timeframes, and CA Health & Code 1367.01.

## III. Planning discharge process for members experiencing a care transition

Anthem will know (in a timely manner) when all members have planned admissions, and when they are admitted, discharged or transferred (experiencing a transition) using ADT feeds or other mechanisms (i.e., data-sharing agreements).

A. Anthem will ensure that all network provider hospitals, institutions, and facilities educate their discharge planning staff on the services, supplies, medications and DME needing prior authorization.

B. **Prior Auth and Timely Discharges:** Anthem will ensure timely prior authorizations and discharges for all members, which includes, but is not limited to, ensuring that prior authorizations required for a member's discharge are processed in a timely manner.

C. **Communication of Assignment to the Care Manager** Anthem will communicate both with the responsible care manager (or contracted care manager) and with the facility where the patient is admitted (referred to as the "discharging facility") in a timely manner so that the care manager can participate in discharge planning and support access to available services.

   For members receiving TCS, their assigned care managers (including ECM (Enhanced Case Management) and CCM (Complex Case Management)) must be notified within 24 hours of admission, transfer or discharge when an ADT (Admission/Discharges/Transfers) feed is available or within 24 hours of Anthem 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.

   Anthem will notify the identified responsible care manager of the assignment and of the member's admission status, including the location of admission, and ensure that the discharging facility has the name and contact information, including phone number, of the identified care manager in the discharge planning document. The member must be given the care manager's contact information as part of the discharge planning document, as described below.

D. **Care Manager Responsibilities for TCS**
   Once a member has been identified as being admitted, Anthem will identify the care manager, who is the single point of contact responsible for ensuring

completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.

Members must be offered the direct assistance of the care manager, but members may choose to have limited to no contact with the care manager. In these cases, at a minimum, the care manager must act as a liaison coordinating care among the discharging facility, the PCP, and Anthem.

For members enrolled in CCM or ECM, Anthem will ensure that the member's assigned ECM Lead Care Manager or CCM care manager is the care manager who must provide all TCS. For members not enrolled in ECM or CCM, this single point of contact ("care manager") may be employed by the plan or other contracted entities (e.g. the primary care practice, an Accountable Care Organization or, the hospital) as long as the plan ensures that a single point of contact is assigned until needs are met and that all TCS can be completed.

If the member is enrolled in ECM or CCM, and if the care manager responsible for TCS will not continue as their ECM or CCM Lead Care Manager, the member should be connected to their new care manager through a referral.

The care manager responsible for TCS is responsible for coordinating and verifying that members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. Hospital and nursing home staff who help with discharge plans should work with, but do not supplant the need for, a care manager unless the responsibility for TCS is fully contracted out.

The care manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the care manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services and follow-ups, noted below. Based on the phased implementation timeline, the care manager is responsible for completing all required responsibilities outlined below for high-risk members starting on January 1, 2023, and for all members starting on January 1, 2024

1. **Discharge Risk Assessment and Discharge Planning** (Transitional Care)

A core responsibility of the care manager is to ensure that a discharge risk assessment is complete and that a discharge planning document is created and shared with appropriate parties. This discharge risk assessment and discharge planning document may be completed by the discharging facility (and, at a minimum, should be informed by discharging providers). However, the assigned care manager must ensure that it is complete and accurately coordinated, shared with appropriate parties as listed below, and that the member does not receive two different discharge documents from discharging facility and from the care manager.

2. **Discharge risk assessment** should be completed prior to discharge to assess a member's risk of re-institutionalization, re-hospitalization, destabilization of a mental health condition, and/or SUD relapse. As part of this discharge risk assessment done prior to discharge, care managers must ensure that members are assessed to determine if they are newly eligible for ongoing care management services such as ECM or CCM. The discharge risk assessment is not required to be approved by DHCS.
3. Care managers must also ensure a **discharge planning document** is created and shared with the member, member's parents or authorized representatives, and the treating providers, including the PCP, the discharging facility, and the receiving facility or provider in order to facilitate communication and information sharing of the member's specific discharge plan. The discharge planning document should use language that is culturally, linguistically, and literacy-level appropriate, and must include all items as noted in the Amended 2023 MCP Contract, such as:
    a. preadmission status (including living arrangements, physical and mental function, SUD (Substance Use Disorder) needs, social support, DME uses and other services received prior to admission)
    b. predischarge support needs (include members' medical condition, physical and mental function, financial resources, and social supports at time of discharge)
    c. Specific agency or home recommended by the discharging facility based on member's needs and preferences
    d. discharge location and the name of the hospital or facility to which the member was admitted
    e. barriers to post-discharge plans
    f. information regarding available care and resources after discharge (specific services needed after discharge, information regarding services available in the member's community, scheduled outpatient appointment)
    g. the care manager's name and contact information and a description

of TCS

4. **Necessary Post-Discharge Services and Follow-Ups**
   Anthem and their assigned care managers must ensure needed post-discharge services are provided, and follow-ups are scheduled, including but not limited to:
   a. follow-up provider appointments
   b. SUD (substance use disorder) and mental health treatment initiation
   c. medication reconciliation
   d. referrals to social service organizations
   e. referrals to necessary at-home services.

   The care manager must also ensure non-duplication of services provided by other team members (including facility or PCP-based care managers if care management is not fully contracted out).

E. Anthem will ensure that mutually agreed upon policies and procedures for discharge planning and transitional care services exist between Anthem and each of its network providers 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, Anthem authorizing procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur.

G. Anthem will ensure that each member is evaluated for all care settings appropriate to the member's condition, needs, preferences and circumstances. Members will not be discharged to a setting that does not meet their medical and/or LTSS needs

H. **End of TCS**
   TCS will end once the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document. For delegated groups, Anthem will ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. For those who have ongoing unmet needs, eligibility for ECM or CCM should be reconsidered.

**REFERENCES:**

- 2023 National Committee for Quality Assurance (NCQA) UM Standards
- CA_UMXX_013 "Non-Authorization of Medical Services"
- CA_UMXX_117 "Decision and Notification Timeframes"
- California Health & Safety Code §1367.01
- Department of Health Care Services, CalAIM: Population Health Management (PHM) Policy Guide, Updated: May 2023
  DHCS Operational Readiness Contract, Exhibit A Attachment III SOW, section 4.3.11A

**RESPONSIBLE DEPARTMENTS:**

**Primary Department:**
Medical Management

**Secondary Department(s):**
None

**EXCEPTIONS:**

None

**REVISION HISTORY:**

| Review Date | Changes |
|---|---|
| 02/06/24 | • Annual review<br>• Updated Procedure section |
| 10/26/23 | • Off-Cycle review<br>• Updated Policy, Definitions, Procedure, and References sections<br>• Added "Secondary Department(s)" sub-header to match GBD Template format |
| 01/25/23 | • Annual Review<br>• Updated References section<br>• Updated Primary Department from "Utilization Management" to "Medical Management" in header<br>• Removed "Case Management (CM) and Utilization Management (UM)" from Primary Department sub-header under Responsible Departments section to match primary department in header |

| **Section (Primary Department)**<br>**Medical Management** | **SUBJECT (Document Title)**<br>**Continued Stay Review/Care Coordination/ Discharge Planning - CA** |
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| Review Date | Changes |
|---|---|
| 02/03/22 | • Annual Review, no changes |
| 01/27/21 | • Annual Review, no changes |
| 11/11/20 | • Off-Cycle Review<br>• Added language per DMHC request on care not being discontinued during inpatient stay.<br>• Updated procedure section: Review of Medical Necessity |
| 01/29/20 | • Annual Review, updated references |
| 01/30/19 | • Annual Review, no changes |
| 01/30/18 | • Annual Review, updated references |
| 01/30/17 | • Annual review. Updated NCQA reference |
| 02/17/16 | • Updated NCQA references<br>• Changed “drugs” to “medications” and “authorizing” to “reviewing” under medical necessity |
| 03/13/15 | • Removed Healthy Families<br>• Changed wording under discharge planning process for SPD members |
| 03/12/14 | • Updated company name as per a Compliance directive.<br>• Added the word “treating” so as to clarify that Anthem would collaborate with the treating provider.<br>• Removed “WMDS” so as to not be so specific with regards to medical management documentation system.<br>• Updated references. |
| 04/05/13 | • Minor reformatting<br>• Incorporated information from a draft policy (CA_UMXX_009 – “Discharge Planning Services”) that was previously submitted and approved by the state of CA in 2011for the SPD Deliverables into this policy.<br>• Updated references |
| 10/10/12 | • Changed reference from Anthem Blue Cross State Sponsored Business to Anthem Medicaid.<br>• Corrected formatting/grammar |

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|---|---|

| Review Date | Changes |
|---|---|
| | • Changed reference from Care Management to Medical Management<br>• Updated references<br>• Added revision history to policy |