PHM Program Readiness Deliverable Cover Note

Overview:

On January 1, 2023, DHCS is launching the Population Health Management (PHM) Program, which is a cornerstone of California Advancing and Innovating Medi-Cal (known as CalAIM). On October 21, 2022, Managed Care Plans (MCPs) will be required to submit this PHM Program Readiness Deliverable to DHCS describing specific components of their PHM Programs and attesting to their readiness to implement these components prior to PHM Program launch.

In line with requirements established in the three key DHCS guidance documents that build upon the vision and foundational expectations outlined in the Final PHM Strategy and Roadmap – the Amended 2023 Contract, the PHM Program Guide, and the PHM All Plan Letter (APL), [1] the PHM Readiness Deliverable includes specific questions and attestations to which MCPs must respond for review and approval by DHCS.

On January 1, 2023, all MCPs will be required to meet PHM standards and have either full National Committee for Quality Assurance (NCQA) Health Plan Accreditation or otherwise demonstrate to DHCS that the plan meets the PHM standards for NCQA Health Plan Accreditation.[2] Therefore, MCPs are required to attest to NCQA PHM accreditation or equivalent in this PHM Readiness Deliverable.

Directions:
The PHM Readiness Deliverable contains a combination of attestations, longform responses, and multiple choice questions to help the Department gain an understanding of MCPs' readiness to meet specific PHM Program requirements. Please respond to each of the questions below. For attestation and multiple choice questions, the MCP may respond directly in the form. For longform responses, please type and submit separate responses, clearly indicating the question to which the response applies. If the MCP is NCQA accredited, they may leverage components of their NCQA submission in

[1] DHCS will release an APL prior to the end of 2022, which explains that the role of the August PHM Program Guide is to provide details of MCPs' existing contractual requirements for the PHM Program.
[2] PHM standards are one component of NCQA Health Plan Accreditation. Examples of other standards include standards on Quality Management and Improvement, Network Management, Utilization Management, Credentialing and Recredentialing, Member' Rights and Responsibilities, Member Connections, and Medicaid Benefits and Services.

their responses. MCPs should submit one Readiness Deliverable; if there are notable differences between regions in which the MCP operates or between the prime MCP and delegated plan entities, please indicate this as applicable in the responses. For questions and additional information, please email PHMSection@dhcs.ca.gov.

Managed Care Plan (MCP) Name

Name of Individual Submitting Reponses

Title of Individual Submitting Reponses

1. **Please indicate ("Yes" or "No") whether your organization is NCQA Health Plan Accredited for its Medi-Cal line of business.**

   If your organization selected "Yes" above, please also submit your PHM Program Description for NCQA Accreditation as an attachment to this submission.

   If your organization selected "No" above, please indicate when you intend to obtain NCQA Health Plan Accreditation and describe existing efforts that are underway to meet NCQA PHM standards ***(250 words or less).***

Gathering Member Information:

2. ***(250 words or less)*** Please describe the Managed Care Plan's (MCP) approach for conducting the Health Information Form (HIF)/Member Evaluation Tool (MET) screening and monitoring of the Individual Health Appointment (IHA). Please indicate in the description whether and how the process will change for Calendar Year 2023, as appropriate. Include in your description responses to the prompts listed below.
   a. How the HIF/MET and IHA are administered to Members (e.g., electronically during member assignment process);
   b. Whether and to what extent the MCP will delegate the HIF/MET to the provider level;
   c. Processes or data sharing mechanisms that MCPs and providers will use to communicate HIF/MET and/or IHA results;
   d. Historical and expected response rates; and
   e. What are the key performance indicators (KPIs) and Managed Care Accountability Sets (MCAS) measures that are used to track completion of the HIF/MET and IHA and ensure that positive HIF/MET and IHA screens are addressed with appropriate interventions.

3. Until the PHM Service becomes available, MCPs are expected to make a good-faith effort to use as many of the DHCS PHM Program required data sources as possible in their RSS approaches (see table below).

   Please indicate ("Yes" or "No") if, by 1/1/23, the MCP will 1) have access to complete and updated information for each data source listed below and 2) use the data source in their risk stratification and segmentation (RSS) methodology. For each of the data sources where the MCP indicates "No," please provide a brief description **(50 words or less)** articulating the efforts under way to gain access and use in RSS. If the MCP intends on waiting for the PHM Service, that is an acceptable response; please indicate as such.
   a. Screenings and/or assessments
   b. Managed care and fee-for-service medical and dental claims and encounters
   c. Social services reports (e.g., CalFresh, WIC, CalWORKs, In Home Services and Supports [IHSS])
   d. Electronic health records
   e. Referrals and authorizations
   f. MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT); medications for addiction treatment (MOUD, also known as medications for Opioid Use Disorder), and other SUD; and other non-specialty mental health services information[3]
   g. County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system
   h. Pharmacy claims and encounters
   i. Disengaged member reports (e.g., assigned members who have not utilized any services)
   j. Laboratories test results
   k. Admissions, discharge, and transfer (ADT) data
   l. Race, ethnicity, language information
   m. Sexual orientation and gender identity (SOGI) information
   n. Disability status
   o. Justice-involved data
   p. Housing reports (e.g., through the Homeless Data Integration System (HDIS), Homelessness Management Information System (HMIS), and/or Z-code claims or encounter data

[3] In certain circumstances, the sharing of 42 CFR Part 2 data may require a member's signed consent in accordance with state and federal law; please refer to the 2022 DHCS Data Sharing Authorization Guidance for more information.

q. For members under 21, information on development and adverse childhood experiences (ACEs) screenings

4. ***(250 words or less)*** **For the answers provided above to the "Gather Member Information" questions, please indicate if there are notable differences between service areas in which the MCP operates or between the prime MCP and delegated plan entities. If there are none, please indicate as such.**

Understanding Risk

RSS

5. As established in the PHM Program Guide, please attest ("Yes" or "No") that the MCP will meet the key requirement of having an RSS methodology in place beginning on 1/1/23.

6. ***(250 words or less)*** In the period before the PHM Service goes live, please describe the following:
    a. The MCP's risk stratification and segmentation (RSS) methodology and specifically what outcomes are optimized in the methodology (e.g. reduced cost, readmission, etc.).
    b. How the MCP defines a significant change in health status and/or change in a Member's level of care and what data and/or process they use to track it.
    c. How the MCP's RSS approach is used to connect members to appropriate interventions and services.
    d. What KPIs are used to track outputs of the RSS and effect on outcomes (e.g. readmission, utilization, health indicators).

7. Please attest ("Yes" or "No") that the MCP will conduct re-stratification during each of the following instances:
    a. For all Members upon enrollment
    b. Annually after each Member's enrollment
    c. Upon a significant change in the health status or level of care of the Member
    d. Upon occurrence of events or new information that may change a Member's level of risk and needs (including, but not limited to, referrals for Complex Care Management [CCM], Enhanced Care Management [ECM], Transitional Care Services, and Community Supports

8. ***(250 words)*** Please describe how the MCP's RSS approach will avoid and reduce biases to prevent the exacerbation of health disparities. **Examples of possible methods may include but are not limited to:**

a. Incorporating all relevant data, including race, ethnicity, primary language, and disability data, and social risk information
b. Continuous performance evaluation with the member population and RSS outputs
c. Using a collaborative design process with clinicians' input for the development of the RSS model
d. Using appropriate metrics to measure the accuracy of RSS model prediction
e. Other

9. ***(250 words or less)*** **For the answers provided above to the "Understanding Risk" questions, please indicate if there are notable differences between service areas in which the MCP operates or between the prime MCP and delegated plan entities. If there are none, please indicate as such.**

Assessment

10. Please attest ("Yes" or "No") that each of the populations listed below will receive the appropriate assessment of their needs. Please also indicate (yes or no) if the MCP intends to delegate the assessment to the provider level.
    a. Members with Long Term Services and Supports (LTSS) Needs
    b. Members in Complex Care Management (CCM)
    c. Members in Enhanced Care Management (ECM) – *delegation of this assessment to the provider level is required by ECM program requirements*
    d. Children with Special Health Care Needs
    e. Pregnant Individuals
    f. Seniors and Persons with Disabilities who meet the definition of "high risk" as established in existing APL requirements[4]
    g. Members who are identified through MCP's own RSS approaches

11. ***(250 words or less)*** As established in the PHM Program Guide, for Members with Long Term Services and Supports (LTSS) needs, DHCS' standardized LTSS referral questions will continue to be required. Briefly describe the MCP's assessment process for this population, including whether the MCP will use the optional Health Risk Assessment (HRA) tool and what KPIs are used to track completion rates of the assessment questions and follow up for members with needs identified.

[4] APLs 17-012 and 17-013

Providing Services and Supports

Basic Population Health Management

Primary Care

12. ***(250 words or less)*** Please describe the MCP's approach to ensure that all members are engaged with their assigned Primary Care Provider (PCP) to the greatest extent possible (e.g., through regular information sharing with network PCPs, regular utilization reports, health education materials, and/or other methods), including delegated responsibilities to PCPs such as care coordination or health education functions if the MCP chooses to do so. Please describe KPIs used to track PCP engagement and continuity with their assigned PCP, as well as stratifications to monitor health disparities in PCP engagement.

    (250 words or less) Please describe how Members who have not been seen by their assigned PCP for 12 months or more will receive outreach and be supported to reestablish contact with their PCP (e.g., through health education materials, direct outreach via phone or mailing, partnerships with PCP offices to conduct outreach, other methods). Please also describe delegated responsibilities to PCPs such as outreach functions if the MCP chooses to do so.

13. ***(250 words or less)*** Please describe the MCP's approach to ensure that all children under the age of 21 receive all screening, preventive, and medically necessary diagnostic and treatment services and immunizations as required under the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and consistent with the AAP Bright Futures periodicity schedule and the ACIP childhood immunization schedule. Please include all KPIs used to track provision of various elements of the EPSDT benefit as well as stratifications to monitor health disparities in EPSDT utilization.

Provision of Whole-Person Care with Other Delivery Systems

14. ***(250 words)*** MCPs are required to ensure that Members receive whole-person care, including through coordination with other delivery systems. As such, please describe the MCP's current processes in place to ensure holistic care management and coordination happens successfully (e.g., data sharing, communication protocols, interdisciplinary case conferencing). Include examples of how the MCP manages the care of a complex Member with needs across delivery systems. Please include specific KPIs that are used to track care coordination across delivery systems.
    a. Specialty Mental Health System
    b. Drug Medi-Cal (DMC) and DMC Organized Delivery System (DMC-ODS)
    c. Long Term Services & Supports (e.g., 1915(c) waivers, In-Home Supportive Services [IHSS])

15. MCPs either currently or will be required to have relationships with additional entities, including schools, local public health and social benefits programs to better ensure members' comprehensive needs are met. The Department is interested in understanding more about how the MCP has started preparing for these efforts. Please indicate ("Yes" or "No") with which entities listed below the MCP has existing partnerships. Please also indicate ("Yes" or "No") if you have an established agreement with the entities below:
    a. Local Education Agencies
    b. Local Health Departments
    c. California Work Opportunity and Responsibility to Kids (CalWorks)
    d. CalFresh
    e. Women, Infants, and Children (WIC) Supplemental Nutrition Programs
    f. First Five programs and providers
    g. Early Start
    h. Supplemental Security Income (SSI)

    (100 words each) For each of the entities/programs where the MCP indicates having an existing partnership, please also respond to the following prompts:

    a. How do the MCP and the entity work together? How often do they meet?
    b. Does the MCP provide financial support/investment in these other entities/program?
    c. Is there involvement in boards/governance structures?

16. **Attestation:** Please attest ("Yes" or "No") that beginning on 1/1/23, the MCP will have or is actively working on initiatives, programs, or processes to address each of the requirements listed below.

    Prevention and Wellness
    a. Monitoring the provision of wellness and preventive services by PCPs as a part of the MCP's Site Review Process
    b. Supporting Members in setting and achieving wellness goals
    c. Providing health education materials that meet the health education and cultural and linguistic needs of Members

Chronic Disease Management

Offering evidence-based disease management programs in line with NCQA requirements that target (at a minimum) diabetes, cardiovascular disease, asthma, and depression. If another is offered, please provide a brief description of the program(s) in ***100 words or less.***

Closed Loop Referrals

The MCP is actively working towards establishing Closed Loop Referrals with the following entities by 1/1/2025:

a. ECM
b. Community Supports
c. Services provided by Community Health Workers (CHWs), peer counselors, and local community organizations;
d. Other community-based social services;
e. Medi-Cal dental providers;
f. California Children's Services (CCS)
g. Developmental Services (DD)
h. CalFresh
i. WIC Supplemental Nutrition Program providers;
j. County social service agencies and waiver agencies for IHSS and other Home and Community Based Services (HCBS);
k. The appropriate delivery system for mental health services to ensure members receive timely mental health services (in the MCP provider network, county Mental Health Plan [MHP] network, or Medi-Cal FFS delivery system) without delay regardless of where they initially seek care, in accordance with DHCS' "No Wrong Door" policy.[5]
l. The appropriate delivery system for Substance Use Disorder (SUD) services (in the Drug Medi-Cal [DMC] or Drug Medi-Cal Organized Delivery System [DMC-ODS]).[6]

17. **(250 words)** Please provide narrative information on MCP's approach, including timing for ensuring that members receive Closed Loop Referrals to appropriate services as specified by the PHM Program Guide, including to:
    a. Community Supports
    b. Services provided by Community Health Workers (CHWs), peer counselors and local community-based organizations
    c. LTSS services (e.g., 1915c waivers, In Home Supportive Services [IHSS])
    d. Timely non-specialty mental health services (NSMHS) and/or specialty mental health services (SMHS) from the appropriate delivery system (in Medi-Cal MCP's provider network, county MHP's network, or Medi-Cal FFS system), in accordance with the No Wrong Door Policy. [7]

[5] APL 22-005: No Wrong Door for Mental Health Services Policy
[6] 2024 Re-Procurement, Exhibit A, Attachment III, 5.5; This requirement will take effect in 2024.
[7] APL 22-005: No Wrong Door for Mental Health Services Policy

18. Please provide narrative information on the MCP's approach to Basic Population Health Management on the following:

    a. ***(250 words)*** **Wellness and Prevention:** Please describe the types of wellness and prevention programs the MCP offers. Please include what KPIs are being used to track the utilization and efficacy of these wellness and prevention programs (both operational and clinical)

    b. ***(250 words)*** **Innovation*:*** Please describe an example of an innovative BPHM program that the MCP has implemented over the past year to meet the Comprehensive Quality Strategy's Bold Goals.

Community Health Worker Integration Plan

19. All Plan Letter (APL) 22-XXX establishes guidance for MCPs in implementing the Community Health Worker Services Benefit. This APL requires MCPs to submit a CHW Integration Plan for DHCS review and approval. Given the interconnectedness between the CHW benefit and the PHM Program, DHCS is including the CHW Integration Plan as part of this PHM Readiness Deliverable.

    a. ***(200 words)*** **Integrating CHWs into PHM**
        i. Please describe how the MCP will assess member needs, determine priority populations using a data driven approach, and connect identified Members to needed CHW services.
        ii. Describe how the MCP's approach for integrating CHWs addresses the following Comprehensive Quality Strategy clinical priorities: children's preventive care, underutilization of primary care, maternity care and birth equity, and integrated behavioral health.
        iii. Please describe how the MCP plans to use CHWs to help address basic population health management, improve engagement, quality and health equity and improve efficiencies.
        iv. Please describe the MCP's referral pathways to CHW services.

    b. (250 words) **Building provider networks for the CHW Benefit**
        i. Please describe whether the MCP has any CHWs on staff and what tasks they perform.
        ii. Please describe the MCP's strategies for recruiting and growing the CHW provider network.
        iii. Please describe whether the MCP will use its existing Provider Network and partnerships with CBOs to fill identified service gaps.
        iv. Please describe the MCP's approach to leverage the skills and assets of external organizations such as Providers, health systems, CBOs, and LHJs to support CHWs.

v. Please describe the MCP's referral pathways to CHW services, including how the MCP ensures Closed Loop Referrals.

c. (100 words) **Intersection with ECM and Community Supports**

i. Please describe, if applicable, how the MCP is contracting or will contract with organizations with CHWs on staff to serve as ECM Providers and/or Community Supports Providers.
ii. Please specify how the MCP will ensure non-duplication between payment for ECM/Community Supports and the new CHW benefit.

d. ***(100 words)*** **Communicating to members about the scope of practice, benefits, and availability of CHW services**

i. Please describe the MCP's approach for member communication in a culturally and linguistically appropriate manner, including written notice, webpage, and other communication tools that inform members how to avail and utilize CHW services.

e. ***(100 words)*** **Communicating to providers about the scope of practice, benefits, and availability of CHW services**

i. Please attest ("Yes" or "No") to the inclusion of a CHW scope of service in the MCP's Provider Manual.
ii. Please describe the MCP's approach for provider training on scope of practice, integration of CHWs in care teams, and referrals to CHW services.

f. ***(250 words)*** **Monitoring Strategies**

i. Please describe the MCP's approach for measuring baseline utilization, including the KPIs used to monitor utilization, and strategies for increasing member utilization of CHW services over time.
ii. Please describe the MCP's approach to monitoring and evaluating the success of CHWs in improving health outcomes, reducing health disparities, and achieving health equity in the short and long term. Please list the KPIs used to monitor and evaluate the CHW program and describe how those KPIs are utilized to ensure equitable provision of services.

Care Management Programs

Enhanced Care Management (ECM)

20. Please attest ("Yes" or "No") that the MCP is preparing for the implementation of the ECM Populations of Focus that go live in 2023.

21. ***(250 words)*** Please describe how the MCP is demonstrating sustained growth of members receiving ECM. Include in your description information about how the MCP is ensuring the equitable provision of services that do not introduce disparities in ECM utilization on the basis of race, ethnicity, language, or other disabilities. Please list the KPIs used to track eligibility, assessment, and enrollment of members into ECM as well as overall penetration of the ECM program. Please include information regarding how those KPIs are utilized to ensure equitable provision of services.

Complex Care Management

22. Please attest ("Yes" or "No") to the following statements about the MCP's CCM program:
    a. Members in CCM receive a comprehensive assessment.
    b. Members in CCM will have a Care Management Plan (CMP) that will include goals, monitoring and follow up.
    c. The MCP will assign a Care Manager for every member receiving CCM.

23. ***(500 words)*** Please describe the MCP's Complex Care Management program. Be sure to include details about the following:
    a. The types of interventions and conditions the program includes
    b. How the program addresses health disparities
    c. Eligibility criteria
    d. The care model and care team or team(s) involved in managing the care of enrollees
    e. If the MCP delegates, or intends to delegate, the CCM program to the provider level
    f. The target penetration rate (% of the MCP's total Membership as well as % of high-risk membership) will be served in CCM on an annual basis
    g. KPIs used to track eligibility, outreach, assessment and enrollment into CCM, as well as stratifications to ensure program addresses health disparities and equitable provision of services

Transitional Care

24. MCPs are expected to use ADT feeds to know when their members are admitted, transferred or discharged when they are available. To what extent does the MCP have ADT feeds and is able to use them? **Please select all that apply:**
    a. The MCP has and utilizes ADT feeds for every acute care hospital in the counties in which they operate.

b. The MCP has and utilizes ADT feeds for a subset of acute care hospitals in the counties in which they operate. **(Please explain in no more than 100 words what the barriers are for obtaining ADT feeds for the remaining hospitals)**
c. The MCP has and utilizes ADT feeds for acute care hospitals in a subset of counties that they operate in. **(Please explain in no more than 100 words what are the barriers for getting ADT feeds for the remaining counties)**
d. The MCP has and utilizes ADT feeds for the hospitals where their members receive the majority of their acute care. **(Please describe what percent of admissions the MCP receives ADT feeds from and how other hospitals who do not send ADT feeds notify the MCP when members are admitted)**
e. The MCP has and utilizes ADT feeds for inpatient psychiatric admissions
f. **Please describe if the MCP uses any other ADT feeds (no more than 250 words)**

25. When ADT feeds are not available, what mechanisms does the MCP use to know when its members are admitted, transferred, or discharged? **Please select all that apply AND describe in no more than 250 words.**
    a. Contract or data sharing agreements with facilities (hospitals, psychiatric hospitals, SNFs, etc.)
    b. Contract or data sharing agreements with other payers (Medicare Advantage [MA] plans, County MHPs, DMC-ODS, etc.)
    c. Leveraging Treatment Authorization Requests or Utilization Management systems
    d. Other

26. MCPs are expected to support members during transitions even if they are not the primary payer for the triggering service (i.e. psychiatric hospitalization, or inpatient admission). How will the MCP enable coordination between payers to know when members are admitted, discharged, or transferred and then support member-centered transitional care services? **Please select all that apply AND provide an explanation of no more than 250 words.**
    a. Improve data sharing through data use agreements with facilities
    b. Improve coordination with roles and responsibilities with facilities
    c. Improve data sharing with County MHPs and DMC-ODS
    d. Improve data sharing through standardized consents and release of information
    e. Delegate coordination to the care manager
    f. Other

27. **Attestation:** Please attest ("Yes" or "No") that beginning on 1/1/23, the MCP will adhere to the below requirements as part of providing Transitional Care.

    a. The MCP acknowledges they are responsible for all transitional care requirements for all its assigned Members, even if the MCP is not the primary source of coverage for the triggering service (except for members enrolled in Dual Eligible Special Needs Plans [D-SNPs]).
    b. The MCP has policies and procedures in place to process prior authorizations in a timely manner, as defined in the contract.
    c. When an MCP's Member is admitted, the MCP will assign a care manager who will be responsible for ensuring completion of all transitional care management services (or notify the member's existing care manager if the member is already enrolled in ECM or CCM).
    d. For members receiving transitional care services from their ECM or CCM Care Manager, the MCP will notify the ECM or CCM Care Manager about all admission, discharges, and transfers within 24 hours, if there are existing ADT feeds, or within 24 hours of the MCP being aware of admission, discharge or transfer for instances where no ADT feed exists, such as for SNF admissions. Note: this notification timeframe will not apply if the care manager responsible for transitional care services is notified of the admission, discharge, or transfer directly through an ADT feed directly.
    e. The MCP will notify the discharging facility of the name and contact information, including phone number, of the assigned care manager and ensure that this contact information is part of the discharge planning document that the patient receives.

28. ***(250 words)*** Narrative: If the MCP intends to delegate, how will the MCP ensure all delegated entities (e.g., hospital, outpatient clinic, skilled nursing facility) have the necessary information to support a patient experiencing a care transition.

29. ***(500 words or less)*** **Narrative:** Transitions are critical times when members are most vulnerable, but are also the most challenging situations to coordinate as they involve multiple providers, systems, and settings. Please describe a program or policy that you have supported that improves transitions for members including roles and responsibilities for the patient/family, discharging facilities, receiving facilities and/or PCPs, the MCP, and other care team members. Specifically include activities that help ensure members are engaged with and receiving follow up primary care and other follow up needs post-discharge/transfer. Include all KPIs you use to monitor the provision, efficacy and clinical appropriateness of care transitions.

30. **For the answers provided above to the "Providing Services and Supports" questions, please indicate if there are notable differences between service**

areas in which the MCP operates or between the prime MCP and delegated plan entities. If there are none, please indicate as such.

PHM Implementation Monitoring

31. ***(500 words)*** Please describe how the MCP currently assesses the efficacy of their PHM performance and include specific measures used. If the MCP does not currently monitor PHM performance, please indicate that below. Visualizations or screenshots of dashboards are permissible to include (graphics not to exceed three 8.5x11" pages).

32. ***(250 words)*** Please describe how the MCP intends to monitor the PHM performance of delegated plan entities, and if the approach or data collected will differ from that immediately described above.

Appendix: Updated Transitional Care Services Attestation Question
PHM Readiness Deliverable

Overview:

On January 1, 2023, DHCS is launching the Population Health Management (PHM) Program, which is a cornerstone of California Advancing and Innovating Medi-Cal (known as CalAIM). Given the new phased implementation policy for Transitional Care Services, within 30 days of receiving the updated PHM Readiness Deliverable template, Managed Care Plans (MCPs) will be required to re-attest to the Transitional Care Services question and submit for review and approval by DHCS.

Along with the release of this updated PHM Program Readiness Deliverable, DHCS issued the updated PHM Policy Guide, which provides more details regarding the phased implementation policy for Transitional Care Services. Please refer to the DHCS PHM website for more information.

Directions:
The updated PHM Readiness Deliverable contains revised attestation question 27 Please respond directly in the form. MCPs should submit one updated Readiness Deliverable; if there are notable differences between regions in which the MCP operates or between the prime MCP and delegated plan entities, please indicate this as applicable in the responses. For questions and additional information, please email PHMSection@dhcs.ca.gov.

Managed Care Plan (MCP) Name: _____

Name of Individual Submitting Reponses: _____

Title of Individual Submitting Reponses: _____

Transitional Care Services (TCS)

27. **Attestation:** Please attest Yes" or "No" that beginning on 1/1/23, the MCP will adhere to the below requirements as part of providing TCS.

    _____ The MCP acknowledges they are responsible for all TCS requirements for all high-risk Members and populations as defined in Section E. 2) c. Transitional Care Services of the PHM Policy Guide, even if the MCP is not the primary source of coverage for the triggering service (except for members enrolled in Dual Eligible Special Needs Plans (D-SNPs)).

    _____The MCP has and will execute a plan to ramp up capacity to provide Transitional Care Services to all members by 1/1/24. The MCP will provide this plan to DHCS upon request.

_____The MCP has policies and procedures in place to process prior authorizations in a timely manner for all members, as defined in the contract.
_____The MCP has policies and procedures in place to know when members are admitted, discharged, or transferred for all members.
_____When an MCP's Member is admitted and is high-risk as defined in Section E. 2) c. Transitional Care Services of the PHM Policy Guide, the MCP will assign a care manager who will be responsible for ensuring completion of all transitional care management services (or notify the member's existing care manager if the member is already enrolled in ECM or CCM).
_____ For members receiving transitional care services from their ECM or CCM Care Manager, the MCP will notify the ECM or CCM Care Manager about all admission, discharges, and transfers within 24 hours, if there are existing ADT feeds, or within 24 hours of the MCP being aware of admission, discharge or transfer for instances where no ADT feed exists, such as for SNF admissions. Note: this notification timeframe will not apply if the care manager responsible for transitional care services is notified of the admission, discharge, or transfer directly through an ADT feed directly.
_____ For high-risk members as defined in Section E. 2) c. Transitional Care Services of the PHM Policy Guide, the MCP will notify the discharging facility of the name and contact information, including phone number, of the assigned care manager and ensure that this contact information is part of the discharge planning document that the member receives.