Population Health Management (PHM) Advisory Group February Meeting:

Transitional Care Services Policy & Community Reinvestment Policy

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

February 12, 2024

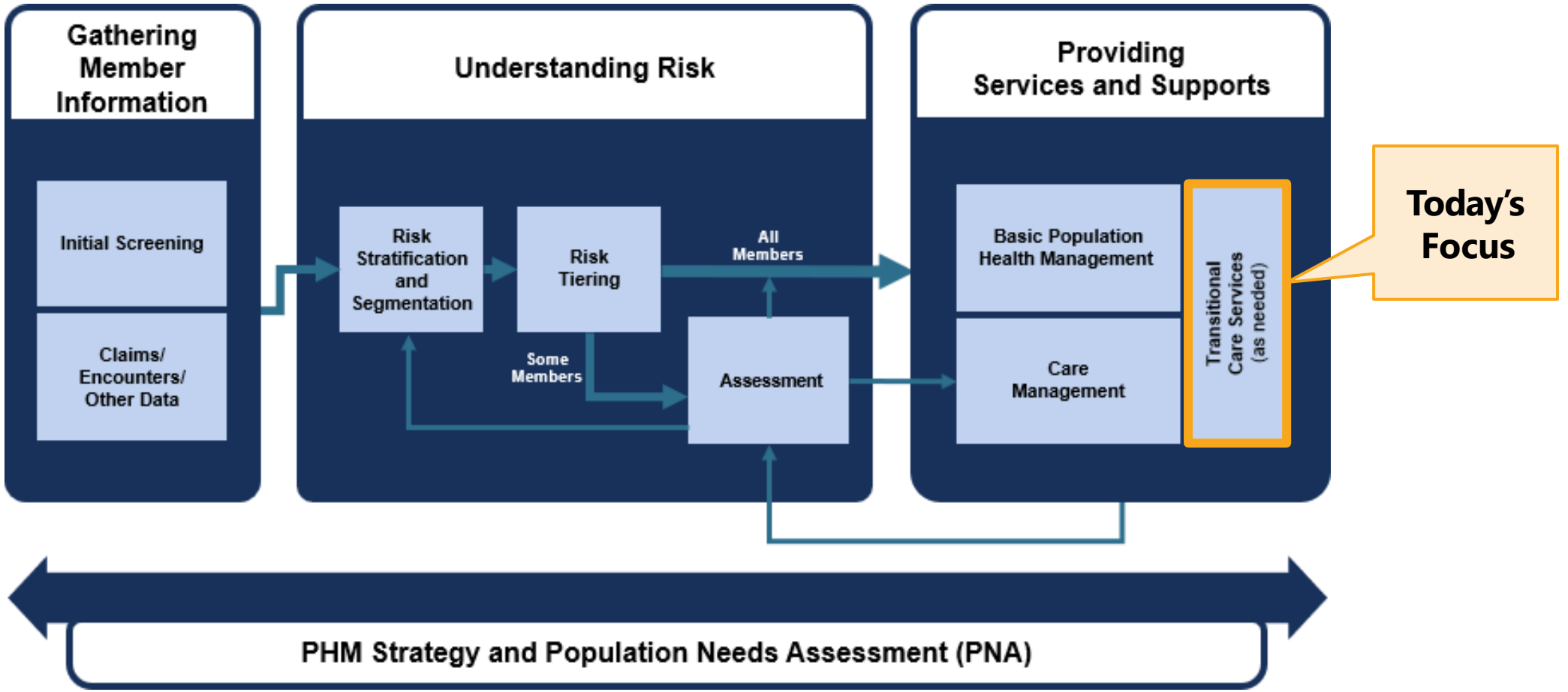
Today's Agenda

- Welcome & Introductions
- Transitional Care Services Policy
  - Overview of Updated Transitional Care Services Policy (Effective 1/1/24)
  - Discussion: DHCS' Priorities for TCS Implementation in 2024
  - Discussion: Improving Referrals to ECM, Community Supports, and Other Services Post- Discharge through TCS
- Community Reinvestment Policy
  - Overview of the Quality Achievement Community Reinvestment Requirements
  - Overview of the Funding Allocation Methodology
  - Review Guiding Principles, Use Categories, and Permissible Community Reinvestment Activities
- Q&A

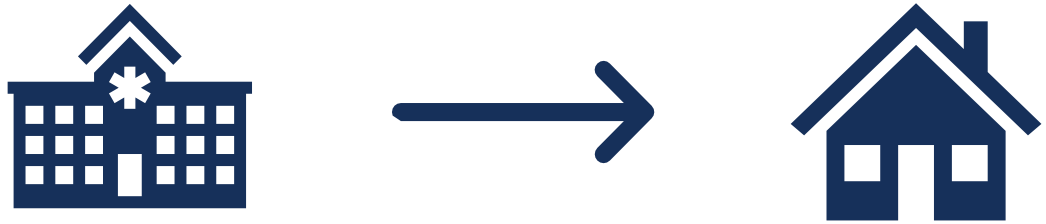
Transitional Care Services Policy

Overview of Updated Transitional Care Services Policy (Effective 1/1/24)

PHM Program Framework



Reminder: Transitional Care Services (TCS)



Transitions of care occur when a Member **transfers 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 to home or community-based settings, Community Supports, post-acute care facilities, or long-term care settings.

Reminder: Goals for TCS

- Members can transition to the **least restrictive level of care that meets their needs and is aligned with their preferences** in a timely manner without interruptions in care.
- Members receive the **needed support and coordination to have a safe and secure transition** with the least burden on the Member as possible.
- Members continue to have the **needed support and connections to services that make them successful in their new environment**.

Phased TCS Requirements since January 1, 2023

DHCS implemented TCS with a phased approach. Services were implemented for high-risk Members on January 1, 2023, with a ramp up to serve all Members starting January 1, 2024.

Phase 1: January 1, 2023

- DHCS required MCPs to ensure **high-risk Members receive all transitional care services including having a care manager/single point of contact** to assist in their transition.

Phase 2: January 1, 2024

- MCPs are required to ensure **transitional care services are complete for all Members**, with different minimum requirements for **high- risk Members** and **lower-risk Members.**

"High Risk" vs. "Low Risk" for TCS

Different minimum TCS requirements apply for high-risk and lower-risk Members.

Defining "High-Risk" for TCS

For the purposes of TCS, **"high-risk" transitioning Members** are defined as:

- Those with LTSS needs
- Those in or entering CCM/ECM
- Children with Special Health Care Needs
- All pregnant individuals, including those admitted during the 12-month postpartum period
- Seniors and persons with disabilities
- Members assessed as high-risk by RSST
- SMH/SUD population
- Members transitioning to or from SNFs
- Members identified as "high-risk" by a discharging facility

Defining "Lower-Risk" for TCS

All other Members are considered "lower-risk" for the purposes of TCS.

TCS Requirements for All Members (Effective 1/1/24)

Beginning in 2024, MCPs are required to implement TCS for **all Members** to ensure they are supported from discharge planning until they have been successfully connected to all needed services and supports.

General MCP Requirements for TCS

- Know when a Member is **admitted/discharged/transferred** (A/D/T)
- Ensure each Member is **evaluated for all care settings** appropriate to their needs
- Ensure the completion of the discharging facility's **discharge planning process**
- Ensure all Members being discharged have a **primary care provider** who can provide follow up care.
- Ensure **referrals** to Community Supports, ECM, and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community Based Services (HCBS) programs
- Ensure **timely prior authorizations**

TCS for High-Risk Members

- MCP must ensure the Member has a **single point of contact** for the duration of the transition. The care manager is responsible for:
  - Outreach to Member
  - Assessment of Member's risk
  - Review of discharge summary
  - Ensure appropriate **clinical information is shared with** the **Member** and follow-up **providers**
  - Ensure **medication reconciliation** is complete post discharge
  - Ensure Members with SUD/mental health needs receive treatment for those conditions upon discharge
  - **Ensure the completion of all recommended follow-up care, including primary care visit**
  - Ensure Members are assessed for **ECM, CCM, and Community Supports** eligibility and referred within 30 days post discharge

TCS for Lower-Risk Members

- Ensure each Member has at a minimum telephonic access to a dedicated TCS team for at least 30 days after discharge.
- Ensure the Member **completes a follow-up primary care/ambulatory visit** within 30 days post discharge, including a **medication reconciliation.**
- Ensure Members are assessed for **ECM, CCM, and Community Supports** eligibility; referred; and outreached for enrollment

Discussion: DHCS' Priorities for TCS Implementation in 2024

Looking Ahead

Given the launch of TCS for all members in January, DHCS is currently focusing on **technical assistance**, especially for MCPs. In 2024, DHCS is engaging with key stakeholders and subject matter experts to learn **best practices, as well as areas for improvement** in existing TCS policy.

Today, DHCS is looking for PHM Advisory Group member input to inform **ways the Department can strengthen and clarify TCS policies in three priority areas** and **how TCS could support improved referrals to ECM, CCM, Community Supports, and other services post-discharge**.

DHCS' Priorities for TCS Implementation in 2024

To continue on the journey of TCS implementation, DHCS has identified the following three priority areas for 2024.

- Connecting Members to **primary care for follow-up** post-discharge
- Ensuring smooth transitions for those transitioning into or out of **skilled nursing facilities (SNFs) and/or needing long-term services and supports (LTSS)**
- Tailoring TCS to **birthing individuals** by supporting transitions of care from pregnancy to the postpartum period

For these TCS priority areas, DHCS is likely to provide additional TA and/or release further guidance to MCPs to ensure Members are fully supported during transitions of care.

For Discussion: Areas for Input on DHCS TCS Priorities for 2024

DHCS is interested in hearing input from PHM Advisory Group members on each of the three TCS priority areas for 2024.

Knowing the importance of primary care follow-up, it is required for both high and low risk members. However, we know that Members are not always connected with primary care providers (PCPs):

- What are some best practices/ways in which Members, PCPs, and primary care support staff can be engaged in primary care follow-up post-discharge? How can trust be built to encourage follow-up?
- How are you supporting primary care engagement for high-risk vs. lower-risk transitioning members?

Members transitioning in and out of SNF or LTC facilities areconsidered high-risk under TCS and therefore are required to have a single point of contact. They often need extra support in accessing resources to remain in the community:

- How can members be best supported to have timely discharges and thrive in community settings?
- What are some of the most critical supports for Members and how can MCPs and facilities ensure these are in place before discharge?

Birthing individuals are considered high-risk under TCS and therefore are required to have a single point of contact. However, we understand these members have unique needs and require varying supports during a care transition:

- Which components of TCS should be tailored to birthing Members to support them during any admission while pregnant or post-partum, especially their admission for the delivery? How can DHCS support better coordination of care for these Members, as they transition from labor and delivery to home?

Discussion: Improving Referrals to ECM, Community Supports, and Other Services Post-Discharge through TCS

For Discussion: TCS and Referral Pathways

TCS does not end until Members are successfully connected to all needed services and supports.

The Challenge:

- One of the requirements for ALL members is that they are referred to ECM, CCM, and Community Supports if they meet eligibility criteria for these services.
- DHCS has heard from discharging facilities that it is challenging to identify
- Members who are enrolled in **Enhanced Care Management (ECM)** and determine who is eligible for ECM for referrals. The same is true for **Complex Care Management (CCM)** and **Community Supports**.[1]

For Discussion:

- How are Members currently **engaged in referral and enrollment** in ECM, CCM or Community Supports? How **is information currently shared between MCPs and discharging facilities** about Members who may be eligible for these programs and services? Any promising practices?
- How can DHCS **strengthen communications and information sharing about ECM, CCM, and Community Supports** so that Members can be referred and enrolled appropriately and have all their transitional care needs met post- discharge?

[1] High-risk transitioning Members who are already enrolled in ECM or CCM will have their ECM or CCM care manager serve as their TCS care manager, fulfilling the single point of contact requirement.

Community Reinvestment Policy

Context for Today's Discussion

- Under the 2024 MCP contract, MCPs and their fully delegated subcontractors with positive net income will be required to allocate 5 to 7.5 percent of their profits toward investments in local communities.
- DHCS is finalizing a draft Community Reinvestment All Plan Letter (APL), scheduled for public comment in Q2-2024.
- DHCS is seeking stakeholder input on its intended Community Reinvestment program in advance of the APL release.

"Base" Community Reinvestment Requirements

All MCPs with positive net income must participate in Community Reinvestment.*

- The percentage of MCP annual net income required to be contributed must be:
  - 5% of the portion of MCP annual net income that is less than or equal to 7.5% of Contract Revenues for the year; and
  - 7.5% of the portion of MCP annual net income that is greater than 7.5% of Contract Revenues for the year.
- Requirements also apply to MCPs' health plan delegates, including:
  - Fully Delegated Subcontractors
  - Downstream Fully Delegated Subcontractors

* Source: CY 2024 Medi-Cal Managed Care Plans Primary Operations Contract, Exhibit B – Budget Detail and Payment Provisions, 1.17 Community Reinvestment

Quality Achievement Community Reinvestment Requirements

In addition to "Base" Community Reinvestment, MCPs with positive net income that do not meet performance targets as defined by the state must invest an additional 7.5% of net income.*

- DHCS has determined that the Quality Achievement Community Reinvestment requirement will apply to MCPs with positive net income that perform in the following Quality Accountability tiers:
  - Tier 2 – Below the State or region median in two Managed Care Accountability Set (MCAS) measure domains.
  - Tier 3 – Below the State and region median in three or more MCAS measure domains.
- The additional obligation applies strictly to net income for any county in which the MCP is in Tier 2 or 3 (based on an allocation of net income relative to Medi-Cal membership by county).
- MCPs are required to direct 100% of their Community Reinvestment funds toward investments focused on improving performance on quality measures below target.

* Source: CY 2024 Medi-Cal Managed Care Plans Primary Operations Contract, Exhibit B – Budget Detail and Payment Provisions, 1.18 Quality Achievement Requirement

Discussion

Are there any questions regarding the Base and Quality Achievement Community Reinvestment requirements?

Guiding Principles for Community Reinvestment Program

DHCS has identified the following guiding principles to underpin the Community Reinvestment program.

Advance Health Equity & SDOH: All Community Reinvestment activities must be targeted toward reducing health disparities and addressing social determinants of health for Medi-Cal populations.

Advance Quality Outcomes for Medi-Cal Members: MCPs that do not meet minimum quality performance standards for the prior measurement year must invest Community Reinvestment funds into activities specifically linked to improving health care quality (as described on the previous slide).

Engage with the Community: MCPs must consult with Community Advisory Committees (CACs) and Medi- Cal members to solicit reinvestment recommendations. Community Reinvestment activities must also be directly informed by the Population Needs Assessment (PNA) process.

Ensure Funding Targets Non-Medicaid Activities: MCPs must ensure that Community Reinvestment activities are non-duplicative of Title XIX/XXI funded services. MCPs may not claim existing investments toward their Community Reinvestment obligations but may use funds to build upon ongoing investments.

Permissible Community Reinvestment Use Categories *

DHCS will require MCPs to allocate Community Reinvestment funds toward a defined set of categories tailored to the specific needs of their communities.

Cultivating Neighborhoods & Built Environment
(e.g., neighborhood revitalization, affordable housing, new wing of a rural health clinic)

Cultivating a Health Care Workforce
(e.g., training programs to address workforce shortages and establish career pipeline for Medi-Cal members; additional staffing to support weekend hours at a community clinic)

Cultivating Well-Being for Priority Populations *(e.g., tailored support for foster children & youth, justice-involved, maternal/child populations, individuals experiencing homelessness)*

Cultivating Local Communities
(e.g., education initiatives, employment & training programs, wellness initiatives to address social isolation)

Cultivating Improved Health Outcomes
(e.g., initiatives to address immediate and long-term health outcomes by targeting improvements in quality measures in which the MCP underperformed)

** Guidance will provide detailed (non-exhaustive) examples of activities that are adequately calibrated to each of the Community Reinvestment categories.*

Discussion

- Do the guiding principles resonate? Are there others to consider?
- Are there any questions regarding the permissible use categories for Community Reinvestment or suggestions as DHCS prepares specific examples of permissible use of Community Reinvestment funds?

Leveraging Community Input on Reinvestment Decisions

Community Reinvestment activities must be informed by the Populations Needs Assessment (PNA) process as well as input from Community Advisory Committees (CAC) and other community stakeholders.

Alignment with the PNA

- MCPs meet PNA requirements by meaningfully participating in the Community Health Assessment (CHA) / Community Health Improvement Plan (CHIP) processes led by local health jurisdictions (LHJs). This requirement took effect in January 2024.
- The Community Reinvestment APL will require MCPs to target funds to the unique needs of each community served, including by demonstrating that Community Reinvestment initiatives are directly informed by the CHA.
- The APL will also encourage MCPs to invest in CHIP-identified activities (the CHIP is the action plan for how each LHJ will use the data identified in the CHA to improve health).

Engaging CACs and Community Stakeholders

- MCPs will also be required to engage their CACs and other community stakeholders to solicit recommendations on how their Community Reinvestment funds are allocated and validate proposed Community Reinvestment Plans.

Additional Information on MCP Deliverables & Community Reinvestment Timelines

- **Draft APL Release**. The APL will include additional details on DHCS' requirements for MCP Community Reinvestment Plans and Community Reinvestment Report deliverables.* DHCS will provide templates for MCPs to complete the Community Reinvestment deliverables.
- **Notice of MCP Funding Obligation**. DHCS will communicate Community Reinvestment funding obligations to MCPs after the close of each calendar year (starting with CY 2024) once net income and Quality Accountability tiers are known.
- **MCP Community Reinvestment Plan Submission and Approval**. MCPs will submit their Community Reinvestment Plans upon receipt of their funding obligations and after validating reinvestment recommendations with their CACs. DHCS intends to review and approve Community Reinvestment Plans within 2 months of submission.
- **MCP Implementation of Community Reinvestment**. MCPs will begin expending Community Reinvestment funds after DHCS approval of their Community Reinvestment Plans. MCPs will begin funding Community Reinvestment initiatives in Calendar Year (CY) 2026 for Community Reinvestment activities based on CY 2024 net income (i.e., the implementation year).

** Under the CY 2024 MCP contract, MCPs will annually submit a **Community Reinvestment Plan** for DHCS' approval that details its anticipated Community Reinvestment activities for each successive calendar year. After the conclusion of each Community Reinvestment funding cycle, MCPs will also submit a **Community Reinvestment Report** that details how its funds were allocated and outcomes from the investments.*

Closing Discussion

Are there any additional questions or feedback related to DHCS' intended Community Reinvestment policy before we adjourn?


Q
A

Appendix

TCS Requirements for High-Risk and Lower-Risk Members (Effective 1/1/24)

Requirements for High-Risk Transitioning Members (Clarification)	Responsible Entity	Requirements for Lower-Risk Transitioning Members (Modification)	Responsible Entity
Assign/Notify Single Point of Contact/Care Manager If the member is enrolled in CCM or ECM at the time of transition, the assigned care manager must be the ECM Lead Care Manager or CCM care manager.	MCP	**Dedicated Team/Phone Number for Member Contact** MCP must ensure transitioning members have a dedicated number to call to connect to a dedicated TCS team who can access discharge documents, if needed.	MCP/ Delegate
Discharge Planning Process The assigned care manager should receive, and review discharging facility's discharge information and ensure it is shared with members and post-discharge providers.	Care Manager	**Discharging Planning Process** MCPs must oversee and ensure facilities complete a discharge planning process in accordance with federal and state requirements.	Discharging Facility with MCP Oversight
Complete All Follow Ups The assigned care manager must ensure the completion of medication reconciliation and any recommended follow-up doctor appointments/ referrals to social services or community organizations.	Care Manager	**Complete PCP/Ambulatory Follow-Up Visit** MCP must ensure ambulatory follow up appointment is completed within 30 days for necessary post-discharge care and services, such as medication reconciliation.	MCP/ Delegate
Evaluate and Refer Members for ECM/CCM/CS The assigned care manager must ensure any eligible member is referred, including assessing eligibility after discharge and within the 30 days post discharge.	Care Manager	**Evaluate and Refer Members for ECM/CCM/CS** MCP must ensure discharging facility assesses and refers members for ECM/CCM/CS. MCPs must also use their data and admission info to evaluate eligibility for ECM/CCM/CS and conduct outreach for enrollment.	MCP/ Delegate
End TCS Services end when all needs are met (30 days or longer)/enrolled in ongoing care management programs (CCM/ECM).	Care Manager	**End TCS/Enrollment in Care Management** MCPs must continue to offer TCS support through dedicated telephonic team for at least 30 days post-discharge.	MCP/ Delegate