TRANSITIONAL CARE SERVICES FOR MEMBERS WITH LONG-TERM SERVICES AND SUPPORTS NEEDS

A Technical Assistance Resource for Medi-Cal Managed Care Plans

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DHCS
CALIFORNIA DEPARTMENT OF
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EXECUTIVE SUMMARY

DHCS' vision is that Medi-Cal members requiring Long-Term Services and Supports[1] (LTSS) can remain in the least restrictive setting that meets their preferences, needs, and optimizes their quality of life. Medi-Cal Managed Care Plans (MCPs, or plans), have flexibilities to leverage different services and supports to meet each individual's unique circumstances. Given the variety and complexity of available services and supports for this population across the Medi-Cal program, this **Technical Assistance Resource for Medi-Cal MCPs** (TA Resource) is intended to provide concrete promising practices from the field to demonstrate how MCPs can best support their members with LTSS needs undergoing transitions of care. This TA resource will also support MCPs in building relationships with Skilled Nursing Facilities (SNFs).[2] The TA Resource also sets out to enhance MCPs' foundational understanding of different LTSS programs and resources that MCPs can consider and adopt in their own workflows to ensure successful transitions into the least restrictive level of care (LOC).

Care transitions are defined as a member transferring from one setting or LOC 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 LTC settings.

Since January 2023, MCPs have been required to deliver strengthened **Transitional Care Services (TCS)** to ensure that all their members are supported from the start of the discharge planning process, through their transition until they have been successfully connected to all needed services and supports.

DHCS is committed to working with MCPs to strengthen TCS implementation for this population across the state, as highlighted during the in-person "TCS Summit" in March 2024, when MCPs shared examples of promising practices of TCS implementation and requested additional technical assistance given the complexity of needs facing this population. DHCS believes that MCPs are well positioned to help each other with creative thinking about how best to serve this population. MCPs across

[1] See Appendix 3: Key Terminology for the definition of LTSS.
[2] This TCS guidance focuses exclusively on SNFs. Subacute Facilities, Intermediate Care Facilities (ICF), or ICFs for Developmentally Disabled (ICF/DD) are not included.

the state have varying levels of experience with successfully implementing local approaches to improve alternatives to institutional placements for members that could be useful for shared learnings. In this guidance, we highlight Health Plan of San Mateo (HPSM) because of their lengthy experience in this space, having established a local approach over a decade ago to improve alternatives to institutional placements for its members. This TA Resource features details about HPSM's approach, as well as promising practices from other parts of the state, including areas served by L.A. Care and Inland Empire Health Plan (IEHP).

Key Promising Practices From The Field

This TA Resource identifies the following promising TCS practices for members with LTSS needs:

1. Building relationships between MCPs and SNFs. Robust relationships between MCPs and providers at all levels of care, but in particular between MCPs and SNFs, are critical to supporting effective transitions of care from hospitals into SNFs and from the SNFs back into the community. Under CalAIM, Long-Term Care (LTC) was carved into managed care statewide in January 2023, with implementation in phases by LTC provider type.[3] Currently, MCPs are in different stages of relationship building with the SNFs in their networks, based on when LTC was first carved into their coverage. Tools like site visits, learning collaboratives, and regular plan-provided onsite education can support relationship building to help the plan and their SNF-partners achieve the goals of TCS and improve quality of care and health outcomes.[4]

2. Ensuring Appropriate Member Placement. Given the current capacity challenges faced by California's SNFs, MCPs must work to distinguish between members in need of SNF-level care from those who can successfully be supported in alternative settings. MCPs can ensure successful transitions by providing financial incentives to SNFs to proactively ensure appropriate member placement either in SNF-level care or in alternative settings with the right supports.

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[3] For more information on the Long-Term Care Carve, see this Fact Sheet and these FAQs.
[4] MCPs and their SNF partners have a joint interest in working together improve quality of care and health outcomes through the SNF Workforce & Quality Incentive Program (WQIP) and the Medi-Cal Managed Care Accountability Sets (MCAS) quality reporting.

3. MCP Coordination of Programs and Resources. TCS requirements mean that MCPs must integrate and coordinate various services and supports, to be available at the time of discharge, so members can successfully transition from hospitals or SNFs to home- or community-based settings. For example, MCPs can leverage Community Supports and/or Home and Community Based Services (HCBS) programs (such as waivers or In Home Services and Supports (IHSS)), or use Community Supports as a bridge to support members until they are able to enroll in such programs. MCPs can also partner with local providers to help ensure that necessary services and supports are in place after the member is discharged.

How to Use this TA Resource:

The primary audience for this TA Resource is MCPs. MCPs can use information from this TA Resource to move towards more effective and seamless TCS support for their members.

- **MCPs who recently carved in LTC** may find it helpful to review "Appendix 1: Decision Trees for TCS Support" and "Appendix 2: Key Services and Supports for LTSS/SNF Transitions" to gain a deeper understanding of programs, and services available to meet member's LTSS needs, including managed care and carved out programs.
- **MCPs working to improve specific TCS implementation areas** are encouraged to review the "TCS for Medi-Cal Members with LTSS Needs: Promising Practices in California" section of this TA Resource and consider adoption or adaptation of the included TCS implementation strategies. MCPs are also encouraged to develop their own innovative practices in their service areas to improve member outcomes.
- **MCPs looking to understand the big picture and ideas for how to weave services and supports together** can review HPSM's detailed journey of how they have built their program, including successes and missteps, as well as their current operational model weaving together various programs and services to support their member's LTSS needs during transitions in the "Case Study: HPSM's Journey to Coordinate Care Transitions for Members with LTSS Needs."

TCS REQUIREMENTS OVERVIEW

Introduction to TCS

As a key part of the California Advancing and Innovating Medi-Cal (CalAIM or Medi-Cal Transformation) Population Health Management (PHM) program, MCPs have been required to provide strengthened TCS since January 2023.[5] In recognition of poor outcomes specifically associated with gaps in a transition of care, the purpose of TCS is to ensure that members are supported from the start of the discharge planning process and through the transition, until they have been successfully connected to all needed services and supports. In response to stakeholder feedback during initial implementation, DHCS published new clarifications and expectations about TCS in October 2023.

Key Takeaway:

MCPs, hospitals, and SNFs must build relationships and take joint accountability to have successful transitions of care for members with LTSS needs.

DHCS, in its TCS policies, defines transitions as transferring from one setting or LOC to another, including, but not limited to: transfers **from** hospital settings, acute care facilities or SNFs **to** home or community-based settings, post-acute care facilities or LTC settings (including SNFs). Medi-Cal members with LTSS needs may undergo multiple transitions triggering TCS requirements when they transition between acute care settings, LTC settings and the community.[6] Fostering strong relationships amongst MCPs, hospitals and SNFs is of critical importance to effective TCS, as highlighted in examples throughout this document. This TA Resource has a specific

[5] See the PHM Policy Guide for the full TCS requirements.

[6] Although it is not a required component of TCS at this time, MCPs are strongly encouraged to provide Emergency Department (ED) follow up as part of TCS, especially for the highest risk members, noting that current MCAS quality reporting includes ensuring timely follow-up for members with ED visits for mental health or substance use disorder (SUD) reasons.

focus on strengthening the relationship between MCPs and SNFs in response to requests from MCPs for more technical assistance in this area.

Box 1: Three main goals for TCS

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

DHCS' strengthened TCS requirements for members with LTSS needs should be understood in the context of a broader progression under CalAIM/Medi-Cal Transformation under which MCPs hold clearer and more consolidated responsibility for meeting the whole-person needs of their members who are older and/or have disabilities. The CalAIM/Medi-Cal Transformation LTC Carve In requires MCPs to cover and coordinate institutional LTC in a phased approach. It creates a standardized payment approach across the state starting in 2023, and aligns DHCS' and MCPs' financial incentives to provide services in the least restrictive environment.[7] In 2023 DHCS released All Plan Letter 23-004 which codified the responsibility for MCPs to identify an LTSS Liaison to support LTSS Providers in addressing claims and payment inquiries and assist with care transitions to support Member needs.[8] Enhanced Care Management (ECM) and Community Supports, which went live in 2022, both include specific programmatic focus on members with LTSS needs, adding important new responsibilities, opportunities, and tools at the MCP level to serve this population.[9]

[7] Long-Term Care (LTC) Carve-In Transition.
[8] All Plan Letter 23-004.
[9] The PATH Collaborative Planning and Implementation Initiative provides funding for county and regional collaborative planning efforts to support implementation of ECM and Community Supports.

TCS Requirements for Members with LTSS Needs Experiencing Transitions

> **Key Takeaway:**
>
> All members with LTSS needs are high risk and must receive **all** high risk TCS as described in the PHM Policy guide and summarized here.

MCPs must ensure TCS is provided to all members in transition between settings, with different minimum TCS requirements applying for high- and lower-risk transitioning members. "High-risk" transitioning members include **all** members outlined in the PHM Policy Guide,[10] including members with LTSS needs. DHCS recognizes that the needs of members vary across populations and for each unique individual. Plans are expected to deliver TCS services that meet each member's needs. As best practices for TCS are established for subpopulations (e.g., those living with disabilities), DHCS will consider refinements of TCS policies for subpopulations.

Once the discharging facility notifies the MCP of transitioning members either through Admission, Discharge and Transfer (ADT) feeds or other data arrangements and as high-risk per PHM Policy Guide definition, MCPs are required to assign a single point of contact to serve as the care managers to ensure that all required TCS are complete based on members' needs and preferences (see Figure 1 for a summary of required TCS activities). For members already enrolled in ECM or Complex Care Management (CCM) at the time of transition, the MCP must ensure the member's assigned ECM Lead Care Manager or CCM care manager is the identified care manager and provides all TCS.

For members with LTSS needs, the TCS care manager must ensure **both** the regular medical follow-ups and medication reconciliation are completed, **and** that all of members' LTSS needs are met, including through confirmed linkages to services beyond the purview of the MCP. The discharging facility can also newly identify a member with potential LTSS needs.[11] Upon identification, the MCP must ensure a full LTSS assessment,

[10] See Section II. D. 2) Assessment and Reassessment to Understand Member Needs of the PHM Policy Guide for a full list of high-risk transitioning members.

[11] MCPs may identify members with potential LTSS needs for assessments at other points in time through initial screenings, including at member enrollment.

using the required standardized LTSS referral questions.[12, 13] Based on assessment results, the TCS care manger would refer the member to any needed LTSS services and supports and ensure successful completion of any referrals and connections to services. Just like for all members, for those with LTSS needs, MCPs must work with their delivery partners to evaluate members' needs and work to support the member and coordinate care across programs and settings, both within and outside of the managed care delivery system. The programs most pertinent to this population are summarized in the "Services & Supports for Members Experiencing LTSS-Related Transitions" appendix below.

As described in the PHM Policy Guide, TCS support for members must continue until the member has been connected, has access to and is receiving all needed services and supports, including LTSS services. TCS should always extend at least 30 days post-discharge.

Box 2: Application of PHM and TCS Requirements to Individuals Dually Enrolled in Medi-Cal and Medicare

PHM requirements may vary when multiple payers are involved in a member's care, as further specified in the PHM Policy Guide.

- For members enrolled in a Dual-Eligible Special Needs Plans (D-SNP), the D-SNP is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal.[14]
- For those dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or other Medicare Advantage plans, MCPs remain responsible for ensuring all TCS requirements are complete.[15] For these members, as for all other Medi-Cal plan members, the MCP is responsible for assigning a TCS care manager or notifying the existing ECM or CCM care manager (if a

[12] The tools, standardized referral questions are not intended to replace state and federally mandated obligations under The Preadmission Screening and Resident Review (PASRR) requirements.
[13] MCPs are not required to use existing Health Risk Assessment (HRA) tools previously approved by DHCS; although, they may choose to do so. However, MCPs or contract entities must continue to assess members who may need LTSS, using the standardized LTSS questions. See Appendix 3 of the PHM Policy Guide for these standardized LTSS questions.
[14] For additional information on D-SNPs, please refer to the D-SNP Policy Guide.
[15] For additional information, please refer to PHM Policy Guide, Section II. E. 3) Transitional Care Services (TCS), e. Guidance for Members Enrolled in Multiple Payors.

member is enrolled in these programs) of the admission, discharge or transfer so they can provide TCS services throughout the transition.

Figure 1. Requirements for High-Risk TCS

Requirements for High-Risk Transitioning Members	
	**Assign/Notify Single Point of Contact/Care Manager** *Responsible Entity: MCP* The MCP must identify a care manager as the single point of contact responsible for providing longitudinal support and ensuring completion of all TCS across all setting and delivery systems. If the member is enrolled in ECM or CCM at the time of transition, the assigned care manager must be the ECM Lead Care Manager or CCM care manager. For members not enrolled in ECM or CCM, the MCP must assign a care manager.[16]
	**Discharge Planning Process[17]** *Responsible Entity: Care Manager[18]* The assigned care manager should receive and review discharging facility's discharge information[19] and ensure it is shared with members and post-discharge providers.

[16] MCPs may assign a care manager from their own staff or through contracted providers such as hospitals, PCPs, or accountable care organizations. This arrangement for MCP contracted entities to provide TCS is not considered formal delegation and therefore, MCPs would not be subject to requirements outlined in APL 17-004.

[17] TCS requirements build on, rather than supplant, existing state and federal requirements on facilities. For detailed requirements, please refer to the PHM Policy Guide, Section II, 3) iv. MCP Oversight of Facility Discharge Planning Process.

[18] For additional information on the care manager responsible for TCS, please refer to PHM Policy Guide, Section II. E. 3) Transitional Care Services (TCS), c. Minimum TCS Elements and Processes for High-Risk Members.

[19] MCPs can consider adding data sharing requirements for facilities within contracts or letters of understanding for out of network facilities to ensure they receive this information.

Requirements for High-Risk Transitioning Members	
	**Complete All Follow Ups** *Responsible Entity: Care Manager* The assigned care manager must ensure the completion of medication reconciliation and any recommended follow-up provider appointments, including behavioral health providers/referrals to LTSS, social services or community organizations.
	**Evaluate and Refer Members for Needed Services, Including but Not Limited to ECM/CCM/Community Supports** *Responsible Entity: Care Manager* The assigned care manager must assess member needs using standardized LTSS questions and ensure any eligible member is referred to ECM/CCM/Community Supports and other LTSS services, including assessing eligibility after discharge and within the 30 days post discharge.
	**End TCS** *Responsible Entity: Care Manager* Services end when all needs are met (30 days or longer)/enrolled in ongoing care management programs (ECM/CCM) or other LTSS services.

Services and Supports for Members With LTSS Needs Experiencing Transitions

As outlined above, TCS Care Managers must ensure all transitional needs are met, including LTSS needs. TCS care managers should have a broad understanding of existing LTSS programs and services in California that provide valuable resources and supports based on geography, members' LOC needs and existing DHCS policy, including, services carved into managed care, services carved out of managed care, other types of programs and services and 1915(c) waiver programs. For the full list and high-level descriptions of LTSS programs and services, please refer to Appendix 2: Key Services and Supports for LTSS/SNF Transitions. In addition, TCS Care Managers may be able to

leverage the MCP LTSS Liaison as a resource for understanding these programs and services.[20]

TCS care managers must identify the best combination of programs and services that will best meet the member's needs and is available to the member based on: 1) if the service is available, 2) if the member qualifies for the service, 3) the amount of time it will take to obtain the service and 4) member engagement and agreement to the plan. For example, if a member is enrolled in a 1915(c) waiver program, they would not be eligible to receive ECM.[21] However, if the member is able to receive more timely services such as diversion from LTC using assisted living facilities through Community Supports and they also need more intensive care management through ECM, the TCS care manager should consider referring and supporting that member's enrollment in ECM and Community Supports instead.

Given the complexity of supports needed for members with LTSS needs, in Appendix 1: Decision Trees for Care Services Support, DHCS provides a framework for which MCPs, LTSS Liaisons, and TCS care managers could refer to depending on where members are during their transition journey. Based on members' level of LTSS needs, home environment and length of SNF stay, the decision trees include illustrative pathways for LTSS programs and services to which TCS care managers could refer and with which they could conduct hand offs to when members are discharged from the hospital and from the SNF to the community. Please refer to the HPSM case study for a comprehensive example of how HPSM is leveraging some of these programs and services to support their members' transitions.

[20] LTSS Liaison is further defined in Appendix 2: Key Services and Supports for LTSS/SNF Transitions.

[21] See the ECM Policy Guide, Section VI. Program Overlaps and Exclusions.

TCS FOR MEDI-CAL MEMBERS WITH LTSS NEEDS: PROMISING PRACTICES IN CALIFORNIA

The TCS Summit that DHCS held in March 2024, which brought together MCPs, and key representatives from hospitals, SNFs and ECM and Community Supports providers, highlighted several impressive initiatives across the state to support members with LTSS needs transition to the least restrictive LOC that meets their needs and aligns with their preferences. A recurring theme for successful implementation of TCS, brought up several times at the Summit, is the importance of forming relationships between all the local entities involved in the transition. Implementation of TCS for members with LTSS needs experiencing transitions requires robust partnerships and communication amongst MCPs, acute care facilities and SNFs. At the TCS Summit, MCPs shared promising practices that strengthen relationships with SNFs to improve transitions from hospitals to SNFs. HPSM established a local approach a decade ago to improve alternatives to institutional placements for its members. The section below highlights their journey, that started well before CalAIM/Medi-Cal Transformation, in implementing transitional care support for members with LTSS Needs. This section also features promising practices from other parts of the state, including areas served by L.A. Care and IEHP. There is not a one-size-fits-all approach to TCS implementation; based on MCPs' own journey, these promising practices offer potential solutions that could be helpful for MCPs' unique situations to improve TCS support.

1. Building Relationships Between MCPs and SNFs

MCPs at the TCS Summit emphasized that building robust relationships with SNFs in their service areas is at the heart of implementing effective transitions of care from hospitals into these facilities and from the SNFs back into the community. Currently, MCPs are in different stages of relationship building with the SNFs in their network, owing in large part to differences in the timing of when LTC was first carved into their coverage. MCPs in areas with the most recent LTC carve-in have recently begun

Key Takeaway:

Supporting members' successful transitions in or out of a SNF requires MCPs to build relationships directly with SNFs. Plans can adopt or adapt strategies like offering in-person education though a learning collaborative or onsite continuing education session to strengthen relationships with SNF partners.

working with these facilities.[22] Promising practices for relationship building discussed at the Summit include:

- ***Strengthening Existing Relationships by Building Internal Partnerships Across Departments.*** To break down silos, IEHP reorganized three previously independent processes into regional, multi-disciplinary teams to provide TCS care management. IEHP brought their internal inpatient utilization management team, member-facing case management care coordination process, and pharmacy team together to provide a team-based, regional approach to TCS that minimizes gaps in coordination and facilitates streamlined care. These multi-disciplinary teams are able to leverage the existing trust and relationships shared by their utilization management team and the SNFs in their network to facilitate timely completion of prior authorization. The IEHP approach also improves information sharing, promoting smooth transitions into new facilities and empowering the MCP to more easily make proactive arrangements for Members to receive needed services and supports that support secondary discharge.[23]
- ***Establishing Learning Collaboratives.*** HPSM convened a learning collaborative for hospitals and SNFs to come together in person to ideate process improvements around coordination and improve member experience and quality of care during transitions. This collaborative focused on transitions from acute to LTC settings and aimed to reduce bottlenecks, readmissions and length of stay. Collaborative members learned about common SNF pain points, such as difficulty accessing medical record or discharge summary information, insufficient bed capacity, delays in prior authorizations or a lack of understanding of SNF processes or services. Based on these identified bottlenecks, the collaborative identified ways to improve data sharing, personal partnerships, and communication between the plan and SNF facilities. The collaborative also helped create a standardized discharge checklist which enhanced the discharge process for the plan, hospital and SNF enabling them to share information and identify the most-appropriate SNF placement post hospital discharge.[24] Lastly, members of the collaborative selected quality benchmarks to measure the impact of these efforts on quality of care. Prior to the hospital/SNF

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[22] One vehicle for regional collaboration between MCPs and SNFs could be the PATH Collaborative Planning and Implementation Initiative.

[23] Secondary discharges are discharges back to home or community-based settings, after a member's primary discharge from hospital to a SNF or other institutional setting.

[24] MCPs may benefit from establishing data sharing arrangements with waiver programs to receive data about member placement on the waitlist.

collaborative, the separate SNF and hospital collaboratives heavily focused on COVID-19 response during the public health emergency, including collaborating with public health officials to disseminate critical information and best practices, and to establish several Centers of Excellence facilities that were setup to accept and care for members with a COVID-19 positive diagnosis.

- ***Building One-on-One Personal Relationships and Continuing Education.*** At the Summit, plans discussed the critical role of relationship building between the MCP and operational staff at each SNF. To build trusted personal relationships, HPSM conducts in-person site visits at SNFs. HPSM's concurrent review nurses are also assigned to hospitals and SNFs and join interdisciplinary conferencing virtually. Because of these relationships, if a SNF is unwilling to accept a member, the plan is able to pick up the phone to call or text their SNF counterpart to make a plan. Plans at the Summit shared that the high rate of staff turnover at SNFs create urgency to foster personal relationships with and provide education to new staff about MCP resources, key contacts and ways to work together. To achieve this, HPSM provides regular onsite education for SNFs' operational staff. In addition to HPSM, L.A. Care has also focused on building relationships with SNFs. L.A. Care conducts quarterly webinars to inform, train and reinforce programs and services available to members that can aid in diverting and transitioning members to the community. As a plan with large SNF networks, L.A. Care partners with the California Association of Health Facilities (CAHF)—the association that represents LTC facilities—to collect topics of interest from SNFs to cover during the webinars, such as the LTC focused Community Supports. They also partner with CAHF to facilitate communication with and distribution of these resources to SNFs across the state. These approaches help to ensure that SNFs are aware of resources available from the plan partner when they work together.

2. Data Sharing Between MCPs and SNFs

MCPs at the Summit expressed that data sharing between plans and SNF partners remains underdeveloped and is therefore a ripe area for creative solutions. A common theme shared by plans at the Summit was that the lack of a formal data-sharing infrastructure between MCPs and SNFs makes it difficult for the MCP to know when their members are ADT. Plans shared the following promising practices to facilitate communication and data sharing:

Key Takeaway:

Strong relationships between MCPs and SNFs require streamlined communication and strengthened data sharing. Plans can consider establishing incentive programs or investing in technology platforms to improve current data sharing arrangements. In addition, plans should leverage personal relationships to support real-time information sharing when data feeds are unavailable.

- ***Assigning TCS Care Mangers to Specific SNFs.*** L.A. Care assigns MLTSS Nurse Specialists, who have LTSS expertise and relationships with their assigned SNFs, as well as being the main point of contact for their assigned SNFs as TCS care managers. Having a single point of contact for the SNF fosters partnership and improves care coordination of member needs throughout the various stages of the continuum of care. Because of the established relationships with SNFs, these MLTSS Nurse specialists are responsible for overall coordination of LTC, including facilitating coordination with hospitals and facilities for the entire duration of member's transitions regardless of whether a member with LTSS needs is admitted to the hospital or ready to be transitioned home. MLTSS Nurse Specialists' personal relationships with SNF partners allow for open communication between L.A. Care and SNFs to work through issues related to SNF placement and identify community transition-eligible LTC members.
- ***Supporting SNF ADT Feeds.*** SNFs are currently not a required entity in the California Health and Human Services Agency (CalHHS) Data Exchange Framework (DxF), as defined by HSC §1250, and therefore many are not connected to electronic health records, Health Information Exchanges (HIEs) or ADT Feeds. At the time of publication, only 14 of 24 MCPs have any ADT feeds from SNFs. Plans are now exploring methods to incentivize and support their SNFs to send ADT feeds to HIEs or other technology platforms and ADT vendors for SNFs.

3. Placing Members Into SNFs or Alternative Settings.

DHCS has consistently heard from stakeholders that overall bed capacity is limited in SNF settings. MCPs emphasized during the TCS summit that there is not a one-size fits all solution to successful transitions into SNFs when necessary. Plans offered promising practices to address common challenges like SNF placement for members with complex needs and SNF denial of member admission based on perceived care intensity. At the Summit, plans shared promising practices, such as:

Key Takeaway:

MCPs must navigate challenges like limited SNF availability to ensure smooth transitions of care. Plans can navigate limited SNF availability by:

- Diverting members from a SNF to a home with additional supports,
- Providing enhanced rates or incentives to SNFs for complex cases, and
- Ensuring there is a secondary discharge plan in place if members require a SNF stay.

- ***Diverting SNF Stays with Primary Discharges to Home with Additional Supports.*** HPSM emphasized the importance of transferring members from acute care to SNFs only when absolutely necessary for their care. At the Summit, they shared the example of a member that needed a six-week course of intravenous antibiotics. The recommendation from their hospital partner had been to discharge the member to a SNF for this type of care, as they did not have an attendant that could provide the care as often as needed. However, in this case HPSM leveraged community care alternatives for SNF placement, specifically working directly with home health and outpatient infusion centers to support the once or twice daily infusion. To ensure the successful diversion from SNF level care, HPSM communicated with and paid for the increased visits to the home for this individual, leveraging and strengthening their existing contracts with home health agencies. It also required conversations with the providers to work to reduce the burden of prescription administration, for instance switching prescription from antibiotics that needed to be delivered two or three times per day to something administered only once daily. This type of discharge planning requires deep engagement and partnership with providers, home health agencies and other partners but is critical to achieving the goals of TCS.

- ***Forward Planning for Complex Cases.*** Plans will often need to identify solutions prior to a transition to enable SNF placement for members with complex needs. They may need to secure housing supports, specialized equipment, behavioral health care or temporary additional levels of care for acute rehabilitative needs amongst other services. While the concept of early planning is not new, some plans have successfully implemented processes that promote rapid access to SNF-level care. For example, HPSM created separate Letters of Agreement with facilities to enhance payments to SNFs to account for additional costs, so facilities are clinically prepared and can accept highly complex/high-cost patients. HPSM's team works on a case-by-case basis with SNFs on enhanced reimbursement for high-cost clinical situations, such as specialized equipment or drugs. Furthermore, by proactively approaching SNFs with plans for financing complex cases, HPSM has been successful at placing and supporting these members. Additionally at the Summit L.A. Care shared that it has an initiative with SNF partners to implement a new skilled level of care structure with enhanced criteria and rates, to incentivize SNF placement for members who might require higher care intensity or LTC after getting admitted into the facility. Once admitted, concurrent reviews are conducted by the assigned MLTSS Nurse Specialist. Assessment is conducted to identify the appropriate discharge resources and settings for the member. For members who can transition back home or to an alternative community settings, L.A. Care coordinates resources to support successful discharge and prevent transition into an institutional setting. The plan has found that SNFs are more likely to accept a member from the acute inpatient setting if the member is supported by a L.A. Care Nurse Specialist to coordinate and support their discharge needs. For members that need LTC, L.A. Care will work with the SNFs in providing support and case by case arrangements in order to ensure the SNFs have the necessary resources to safely care for the members.
- ***Creating Secondary Discharge Plan Prior to SNF Entry.*** Often the barrier for placing members in SNFs is ensuring a plan for secondary discharge to the community. For those members who require placement into SNFs for acute or sub-acute rehabilitation, MCPs may need a plan, such as referral to housing-related Community Support after the member leaves the SNF after rehabilitation is completed to ensure they will not stay in the SNF long term. Plans at the Summit reported that without such an exit plan, SNFs are reticent to accept members to their facilities. In addition, HPSM incents SNFs to accept their patients and assure the facility of their secondary discharge plan using its Community Discharge P4P program. This program financially rewards SNFs for

successfully discharging HPSM members with extended institutional stays to a community setting where they remain continuously for six months or more. HPSM shared that SNFs reported back that participating in this incentive program has become a significant part of how they approach their work.

4. Identifying and Supporting SNF Members Transition to the Community

Successful discharging of members with LTSS needs from SNFs to community-based settings requires partnerships and coordination with other systems, services, and supports. Members with LTSS needs will often need intensive planning prior to transitions and support in setting up access to medical care, meals, home-based services, caregiver support, and/or assisted living arrangements. TCS Care managers play an important role in connecting members with needed programs and services and additional members of the care team before, during, and after the transition. Individuals may also need modifications to their home environment to make it accessible and safe to use.

- ***Identifying LTC Members Ready to Transition.*** At the Summit, HPSM described how their utilization management and integrated case management teams collaborate to complete a comprehensive assessment of the members to identify individuals that may be ready to transition out of a SNF to the community, using their Community Placement Readiness

Key Takeaway:

MCPs must engage in system-level coordination to meet all of members' needs during transitions of care including advanced planning with SNFs and securing appropriate services and supports in home or community-based settings, such as partnering with local LTSS providers such as Institute on Aging (IOA), helping member placement in Residential Care Facilities for the Elderly (RCFE), or leveraging available Community Supports. Plans can adopt or adapt strategies to: support faster identification of members who are ready to transition, arrange appropriate services for members after the transition and coordinate needed resources to help members remain living independently at home or in community-based living arrangements.

Screening Form.[25] These assessments include determining whether members are eligible for ECM or Community Supports and other LTSS services.

- ***Arranging Assisted Living Facility Placement After Transitions.*** As HPSM first began to help transition members from SNFs to the community, they quickly learned that many of their members could not all immediately transition to living independently at home and some were readmitted back into the SNFs or hospitals. These members either needed SNF-LOC in community setting or required additional services and supports to help them with manage activities of daily living (ADLs). For these members who wish to live in the community, HPSM would directly pay for assisted living placement until the member could successfully enroll in the Assisted Living Waiver (ALW). This allowed members to be transitioned from SNFs to RCFEs before assessing their ability to live independently at home.[26] Once Community Supports went live, HPSM leveraged the Nursing Facility Transition/Diversion to Assisted Living Facilities (ALF) Community Support to facilitate these types of transitions, an example of how Community Supports can play a critical role in bridging between other existing Medi-Cal programs.
- ***Coordinating Services and Leveraging Community Supports.*** At the Summit, HPSM and its partner IOA, a local California Community Transitions (CCT) organization who is also their contracted ECM and Community Supports provider, emphasized the importance of anticipating member needs and securing needed supports to prevent the need for readmission. They work together to refer and setup appropriate services and supports available to assist the member immediately upon discharging from a SNF to the community, especially necessary Community Supports that support nursing facility transitions and housing. IOA, and community-based organizations (CBOs) like them, streamline coordination by serving as the go-between for the MCP and RCFE. To do so, they contract independently with the RCFEs to relieve the MCP of that administrative burden. Please review the Illustrative Example below for more details on this partnership model.

[25] See "Appendix 4: HPSM Community Placement Readiness Screening Form Example."
[26] ALW services are provided to participants by RCFE and Adult Residential Care Facilities (ARF). Please review Appendix 2: Key Services and Supports for LTSS/SNF Transitions for more information.

Case Study: HPSM's Journey to Coordinate Care Transitions for Members With LTSS Needs

Plans can adapt or adopt promising practices from this case study on HPSM to better connect members to the least restrictive setting that meets their needs and preferences.

Over time, HPSM developed a sophisticated approach to coordinating care transitions for Members with LTSS needs, including:

- Building robust systems-level relationships with SNFs and community partners;
- Braiding together multiple programs to ensure coverage for services throughout transition;
- Establishing strong referral relationships in its service area to improve members' immediate access to needed services upon discharge;
- Developing partnerships, through the Community Care Settings Program, with providers like IOA and housing providers like Brilliant Corners, to support transitions from SNFs to the community;
- Scaling the approach with ECM, Community Supports and PHM under CalAIM.

Below are two detailed descriptions of how HPSM helps members transition and live in the least restrictive setting that aligns with their needs and preferences.

1. Establishing the vision, goals, infrastructure, and cultural change needed to deploy a successful 'SNF to community' transitions program:

HPSM's focus on supporting members transitioning from SNFs to community began in 2013. They first assessed their internal capabilities to support members successful transitions to the community. Then they issued a Request for Proposals to identify care transition and housing partners that would support their mission to allow members to live in the least restrictive setting. IOA (as a CCT LO with transition support experience) and Brilliant Corners (a housing provider) bid together to become HPSM's partners in facilitating the transitions. This process was the beginning of HPSM's journey to build out their vision and internal/external capabilities for SNF transitions to the community.

When LTC was carved into managed care for HPSM, SNFs were closing and bed capacity was limited. HPSM found that proactively identifying members and

assisting them to transition to the community would help open up SNF beds for the members who needed that intense LOC in their preferred location. HPSM looked at their internal data as well as the literature and estimated that up to 20% of their LTC members would be able to successfully transition back to the community with appropriate housing and supports. This led them to set an ambitious goal to transition 100 members back the community.

To implement this bold goal, HPSM staff conducted site visits with all the SNFs in their network to build buy-in toward their vision and relationships that would support transitioning members out of an institutional setting. These site visits also allowed HPSM to introduce their partners—IOA and Brilliant Corners—to the SNFs and foster direct relationship building. Later HPSM convened a "Core Group" of community partners including representatives from the local Department of Aging (public guardian, IHSS), Specialty Mental Health/Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan, IOA, Brilliant Corners and other Social Services and medical stakeholders. The Core Group became a mechanism for shared accountability, teamwork and problem-solving for each member slated to discharge from the SNF/LTC setting. This group built psychological safety and trust with one another that empowered them to raise common challenges and successfully pivot to improve upon program delivery and key partnerships. For example, this Core Group provided an opportunity for IOA to elevate a three-month long delay in establishing in home support services which limited their ability to execute successful transitions. By raising this issue to the Core Group, representatives from the local Department of Aging and Adult Services were able to reduce the evaluation for IHSS from three months to closer to two weeks. This performance improvement allowed for faster identification of an IHSS worker to facilitate transition to the community.

This transition program has taken time to build and improve. In the beginning, HPSM fully supported IOA and Brilliant Corners staffing but transitions were slow, at times inappropriate, had high clinical and psychosocial complexity, and several missteps occurred. These challenges offered opportunities for process improvement for the entire Core Group, The process of learning also secured buy-in and shared accountability by the partners. As a result of this collaboration, safe community transitions that typically took 6–9 months to achieve were occurring in 3–4 months. Additionally, members were remaining in the community long-term and utilizing LTSS services regularly.

2. Weaving existing services, programs and supports together to meet members' need and assist them to transition to the community:

HPSM works with their SNF partners to assess members who may benefit from a SNF transition to the community by way of their Community Placement Readiness Screening Form.[27] After a person is identified, the plan leverages the plan-staffed utilization management and intensive case management teams to complete a comprehensive assessment of the members to identify whether they are eligible for ECM or Community Supports and other LTSS services. HPSM then works closely with IOA to facilitate the transition. IOA offers a broad spectrum of LTSS to help seniors maintain their independence as long as it is safe to do so.

IOA works with other organizations in the community and assesses members to identify all the needed supports and services necessary for their transition to a less restrictive setting. These resources include the critical setup of housing—including independent housing or assisted living facilities and other key services such as durable medical equipment (DME), meals or personal care. IOA then collaborates with HPSM to have sufficient lead time to arrange appropriate supports immediately upon discharge for members to reside safely in the community (e.g., DME delivered to the home immediately at discharge, or confirming pharmacy orders to the local accessible pharmacy rather than the hospital). For example, IOA and HPSM coordinate with their partner Brilliant Corners to place members in independent housing which they have worked to expand access by creating set-asides in new developments for their members. IOA also works to proactively to anticipate key TCS needs before the member encounters a common barrier/roadblock, and facilitates ongoing communication and coordination among providers, families and facilities.

For members at SNF-LOC who are looking to transition to alternative care settings such as assisted living facilities, IOA, as both a waiver and a community supports provider, works closely with HPSM to refer members to ALW and CCT program for wraparound support in assisted living facilities, or longitudinal and intensive transition support. In addition to leveraging their own network of assisted living facilities, IOA also works together with HPSM to ensure that members placed on waitlists for ALW have alternative Community Supports in place to be able to transition and live in the community in an RCFE quickly. With this broad group of

[27] See "Appendix 4: HPSM Community Placement Readiness Screening Form Example" for more information.

stakeholders, HPSM was able to establish strong partnerships with providers like IOA that are still thriving today. The plan emphasized the role of building partnerships and trust in facilitating complex discharges.

One pain point HPSM continues to work through is related to placing members in SNFs by proactively planning for the member's secondary discharge. For SNFs to admit new members, the most valuable reassurances are for the MCP and hospital to articulate a plan for secondary discharge for members to eventually transition to the community, often with robust transition support through the ECM and Community Support services. When HPSM connects with hospitals, it emphasizes the goal is to ensure the hospitals understand their role in referring members to ECM and Community Supports services during the member's inpatient stay. By doing so, they help to better facilitate transitions post-SNF discharge and reduce length-of-stay for the member in the SNF. Similarly, IOA's dedicated staff must build trusting relationships with the SNFs and the hospitals to support secondary discharge plans. IOA has dedicated staff to build these relationships. In addition to care management, safe housing is crucial to ensuring safe secondary discharges. Leveraging all the tools available for to support LTSS transitions to a less restrictive setting can help plans foster relationships with SNFs and encourage them to accept member placement.

Application of Case Study to MCP Practices:

MCPs should consider:

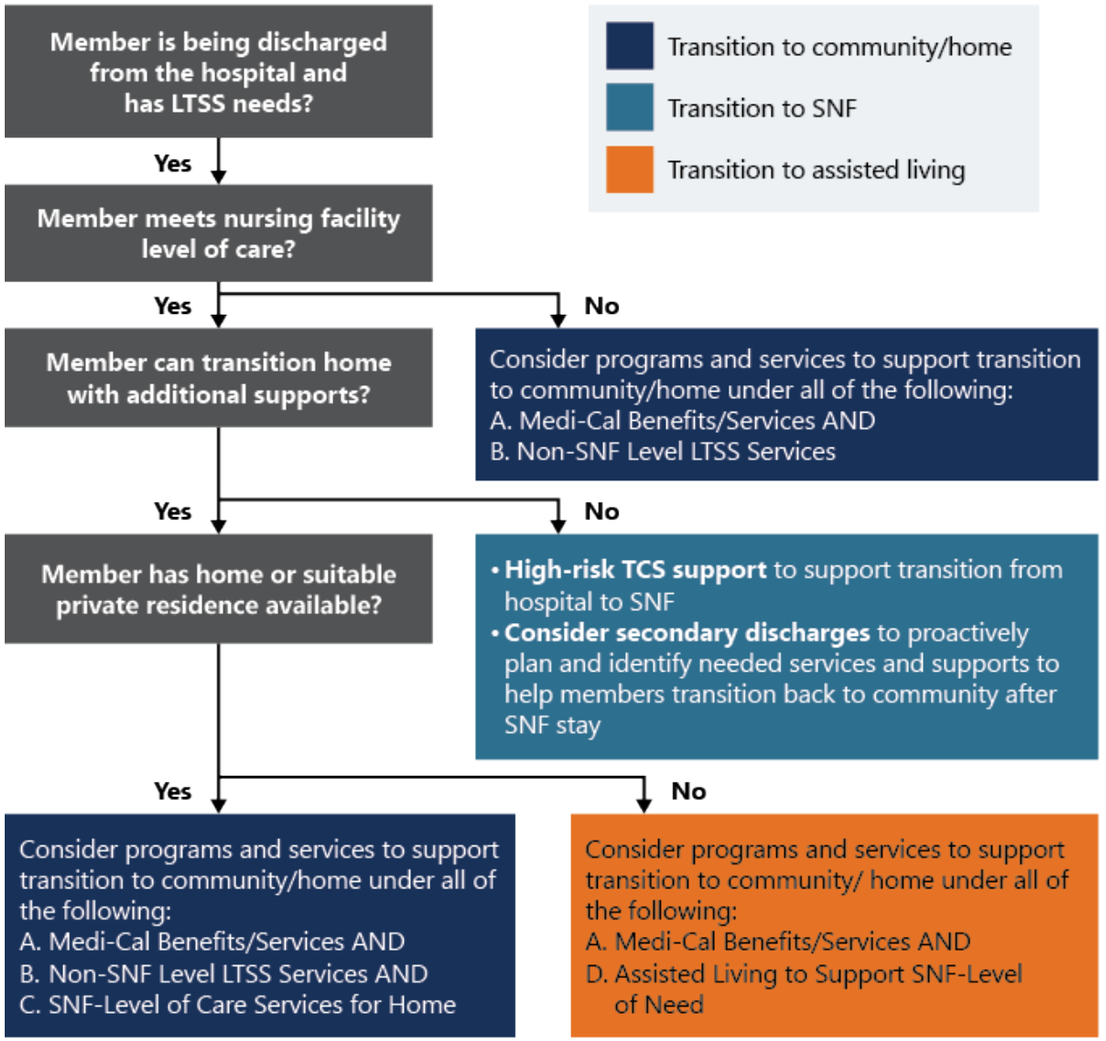
- What is the MCP's vision and specific, measurable goals?
- What resources are needed to strengthen internal capabilities and/or external partnerships to meet those goals?
- How can personnel's roles and functions be clarified to make their responsibilities as it pertains to care transitions explicit?
- How will a culture of trust, collaboration and accountability be developed with partners?
- What services and supports are available and which local organizations can MCPs contract with locally to support members with LTSS needs?
- How will the SNFs be engaged continuously throughout the process?
- How will members be screened to identify best placement for successful transition? (See Appendix 4 for an example assessment)

APPENDIX 1: DECISION TREES FOR TCS SUPPORT

It is important that MCPs and the TCS care manager begin discharge planning process at the time of admission to the greatest extent possible. In the decision trees outlined below, the various programs and services that the TCS care managers could consider referring members to when they move through different points of the transitions are organized by the level of member needs and program/service eligibility criteria, including (A) general Medi-Cal benefits and services not specific to members LTSS needs, (B) non-SNF level LTSS to support members living safely and independently in their homes, (C) SNF LOC services for home and (D) assisted living level of services.

TCS care managers, including ECM Lead Care Managers/CCM care managers if a member is enrolled in ECM or CCM, are the cornerstones in coordinating care for members throughout the transitions across programs, settings and delivery systems. Together with the member's input, TCS care manager must ensure that members' identified needs are addressed and that once a member is referred to appropriate LTSS programs or services, the member has adequate support to navigate through additional assessment and has necessary information as required by the specific program to enroll and receive services.

Graphic 1. TCS Support for LTSS Transitions from Acute Care Hospital



Medi-Cal Programs and Services that Support Transitions for Members with LTSS Needs*:

A. Medi-Cal Benefits/Services to Support Members in the Home
- Benefits/services: e.g., DME, home health, NEMT, and NMT
- ECM Individuals At Risk for Avoidable Hospital or ED Utilization Population of Focus (POF)
- Community Supports: Recuperative Care and Short-Term Post Hospitalization Housing, Housing Navigation, Housing Tenancy and Supports, and Medically Tailored Meals/Medically Supportive Foods

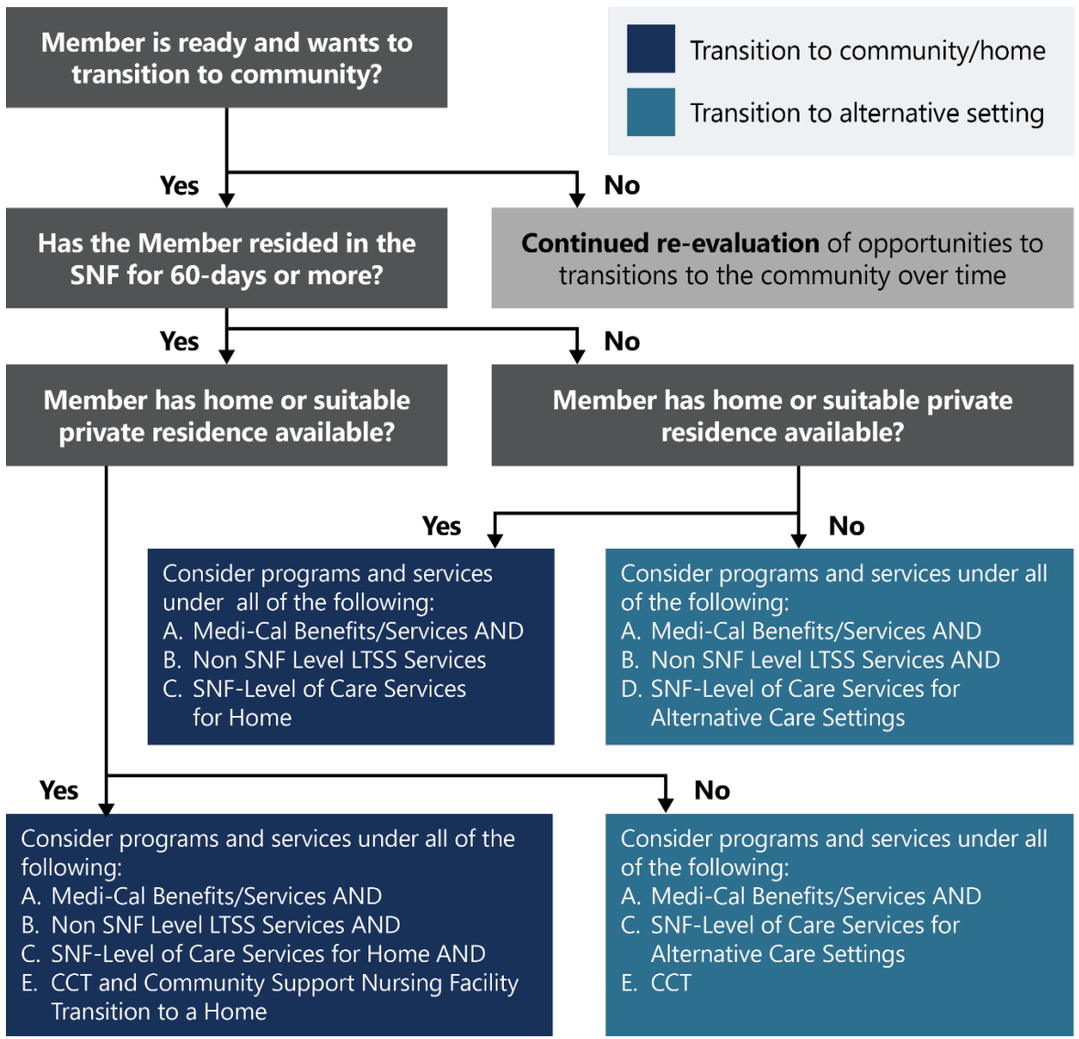
B. Non-SNF Level LTSS Services**
- LTSS-related benefits:
  - In Home Services and Supports (IHSS)
  - Community-Based Adult Services (CBAS)
  - ECM Adults Living in the Community and At Risk for LTC Institutionalization POF
- Optional LTSS services or programs:
  - Community Supports: Home Modifications; Personal Care and Homemaker Services; Respite Services

C. Optional SNF-Level of Care Services for Home to Avoid Long Term Institutionalization
- Program for All Inclusive Care For The Elderly (PACE)
- Multipurpose Senior Services Program (MSSP) Waiver
- Home and Community-Based Alternatives (HCBA) Waiver

D. Assisted Living to Support SNF-Level of Need to Avoid Long Term Institutionalization
- Community Supports: Nursing Facility Diversion to Assisted Living Facilities
- Assisted Living Waiver (ALW)

1. Per TCS requirements in the PHM policy guide and summarized in Figure 1.
*If members are receiving services from existing LTSS programs and services, it may limit their eligibility for other services and supports. For example, if a member is receiving CCT services, they are not eligible for ECM. Please see the ECM Policy Guide for program overlaps and exclusions. Please see each Waiver or Program Specific website for other overlaps or exclusions for any given program.
** **Non-SNF Level LTSS Services** include services or supports that may be beneficial to a member that has LTSS needs including those with SNF level of care needs, but which do not require a certification of Skilled Nursing Facility level of care per CMS regulations as defined by Cal. Code Regs. Tit. 22, § 51124.

Graphic 2. TCS Support for LTSS Transitions from SNF to Community



MCP TCS Support[1]

Medi-Cal Programs and Services that Support Transitions for Members with LTSS Needs*:

A. Medi-Cal Benefits/Services to Support Members in the Home
- Benefits/services: e.g., DME, home health, NEMT, and NMT
- Community Supports for non-LTSS related needs: Recuperative Care, Short-Term Post-Hospitalization Housing, Housing Navigation and Deposit, Medically Tailored Meals

B. Non-SNF Level LTSS Services**
- LTSS-related benefits: In Home Services and Supports (IHSS); Community-Based Adult Services (CBAS)
- Optional LTSS services or programs: Community Supports: Home Modifications; Personal Care and Homemaker Services; Respite Services

C. SNF-Level of Care Services for Home
- ECM Adult Nursing Facility Residents Transitioning to the Community POF
- Program for All Inclusive Care For The Elderly (PACE)
- Multipurpose Senior Services Program (MSSP) Waiver
- Home and Community-Based Alternatives (HCBA) Waiver

D. Assisted Living to Support SNF-Level of Need
- Community Supports: Nursing Facility Diversion to Assisted Living Facilities
- Assisted Living Waiver (ALW)
- ECM Adult Nursing Facility Residents Transitioning to the Community POF

E. Other Programs Listed Individually That Require 60-Day SNF Stay
- California Community Transitions (CCT)
- Community Support Nursing Facility Transition to Home

1. Per TCS requirements in the PHM policy guide and summarized in Figure 1.

*If members are receiving services from existing LTSS programs and services, it may limit their eligibility for other services and supports. For example, if a member is receiving CCT services, they are not eligible for ECM. Please see the ECM Policy Guide for program overlaps and exclusions. Please see each Waiver or Program Specific website for other overlaps or exclusions for any given program.

** **Non-SNF Level LTSS Services** include services or supports that may be beneficial to a member that has LTSS needs including those with SNF level of care needs, but which do not require a certification of Skilled Nursing Facility level of care per CMS regulations as defined by Cal. Code Regs. Tit. 22, § 51124.

APPENDIX 2: KEY SERVICES AND SUPPORTS FOR LTSS/SNF TRANSITIONS

Services Carved into Managed Care:

- **ECM for LTC Populations**.[28] Medi-Cal members who meet "Populations of Focus" (POFs) eligibility criteria are able to receive ECM services. During transitions of care, for those not already enrolled in ECM, MCPs should assess members for ECM eligibility for continued intensive care management. In addition, when a member enrolled in ECM is experiencing a transition of care, their ECM Lead Care Manager is also the TCS Lead Care Manager and responsible for providing all TCS support, including coordinating all follow up care, connecting the member to primary care and needed Community Supports, ensuring the completion of a medication reconciliation and making referrals to social services and supports the member in a safe transition to their new living arrangement. When a member who is at risk for institutionalization/re-institutionalization is being discharged home or when a SNF resident is looking to transition to the community, MCPs should consider referring them to ECM and providing intensive support through the two POFs outlined below. More information on these POFs can be found in the ECM Policy Guide and POF Spotlight dedicated to ECM for LTC populations.

MCP LTSS Liaisons:

TCS Care Managers may be able to leverage the MCP LTSS Liaison as a resource for understanding these programs and services. APL 23-004 mandates that MCPs must identify an individual or set of individuals as part of their Provider Relations or related functions to serve as the liaison for LTSS Providers. LTSS liaisons must assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS Provider community to best support Members' needs. LTSS liaisons do not have to be clinical licensed professionals, they may be fulfilled with non-licensed staff. MCPs must identify these individuals and disseminate their contact information to relevant Network Providers, including SNFs that are within Network.

[28] ECM POF Spotlight for Long Term Care Populations (p. 4-5).

- **Adults Living in the Community and at Risk for LTC Institutionalization**. Designed for members living in the community with complex social needs who are at risk of institutionalization and are unable to manage care for themselves without additional support. They are still able to reside in the community safely and avoid institutionalization if wraparound supports, including in-home visits, are made available.
- **Adult Nursing Facility Residents Transitioning to the Community.** Designed to support members that reside in a SNF and express a desire for a less restrictive setting or to return to a community setting once healed. They are able to reside continuously in the community with additional wraparound supports.

» **Community Based Adult Services (CBAS).**[29] CBAS, formerly Adult Day Health Care, is a Medi-Cal Managed Care benefit that provides services to older adults and adults with chronic medical, cognitive or behavioral health conditions and/or disabilities that make them at risk of needing institutional care. CBAS centers have health professionals who assess each participant to identify and plan services needed to meet the individual's specific health and social needs. For members at risk of institutionalization/re-institutionalization, who are being discharged from hospitals or are transitioning out of SNFs, MCPs and assigned TCS care managers should consider referring and providing CBAS to restore or maintain members' optimal capacity for self-care, so that they can remain in the community. Members receiving support through CBAS are eligible to receive ECM if they meet POF criteria.[30]

» **Community Supports.**[31] Members with LTSS needs undergoing transitions of care may also benefit from many of the 14 preapproved Community Supports that MCPs in all counties have been strongly encouraged to offer since January 1, 2022. For members at risk for institutionalization/re-institutionalization, MCPs should consider some Community Supports that are specifically designed to provide wraparound supports to help them remain in the community. For nursing home residents transitioning in the community, MCPs should also consider certain critical Community Supports to help find housing or independent living arrangement and setup needed wraparound supports in the community before

[29] CBAS is only available in 27 counties.
[30] ECM POF Spotlight for Long Term Care Populations (p. 7-9).
[31] Clarifying guidance on these Community Supports is forthcoming from DHCS.

members transition, so they can successfully reside and remain in the community. MCPs and TCS care managers should work to connect the members they serve with Community Supports, as appropriate. These programs are not uniformly available statewide; see available Community Supports in each county in this Community Supports Elections document.

- **Nursing Facility Transition/Diversion to Assisted Living Facilities (ALF).** Facilitates a member's transition into an ALF, RCFE or ARF for members who are currently receiving medically necessary nursing facility LOC or who meet the minimum criteria to receive nursing facility LOC services. Services include 1) time-limited transition services and expenses that enable a person to establish a community facility residence in an ALF/RCFE/ARF, as well as 2) ongoing assisted living expenses (except room and board) that include wrap-around care (e.g., assistance with ADLs, Instrumental Activities of Daily Living (IADLs), etc.).
- **Community Transition Services/Nursing Facility Transition to a Home.** Facilitates members that have lived 60+ days in a nursing home and/or Medical Respite setting who are transitioning to a private residence where the person is directly responsible for their own living expenses.
- **Environmental Accessibility Adaptations (Home Modifications).** Provides funding for individuals at risk for institutionalization in a nursing facility to receive physical adaptations to a home that are necessary to ensure the health, welfare and safety of an individual, or enable them to function with greater independence in their home.
- **Personal Care and Homemaker Services.** Provides personal care services and homemaker services for individuals at risk for hospitalization or institutionalization in a nursing facility who need assistance with ADLs, such as bathing, dressing, toileting, ambulation or feeding. Entities should refer members to the IHSS program benefits prior to the Personal Care and Homemaker Services Community Support.
- **Respite Services.** Provided on a short-term basis to provide relief to caregivers of members who live in the community and are compromised in their ADLs and therefore require intermittent temporary supervision.
- **Short-Term Post-Hospitalization Housing.** Provides members who do not have a residence and who have high medical or behavioral health

needs with the opportunity to continue their medical/psychiatric/ substance use disorder recovery immediately after exiting an inpatient hospital, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility or recuperative care and avoid further utilization of state plan services.

- **Housing Transition Navigation Services.** Provides services that assist members with obtaining housing, based on assessed needs.
- **Housing Deposits.** Assists with identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board.
- **Medically Tailored Meals/Medically-Supportive Food.** Provides Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
- **Recuperative Care.** Provides short-term residential care for individuals who no longer require hospitalization, but still need to recover and receive post-discharge treatment from an injury or illness and whose condition would be exacerbated by an unstable living environment.

Services Carved Out of Managed Care:

In the below sections on Services Carved Out of Managed Care and Other Programs and Services, high-level descriptions are provided with links to more information from the state. The availability of these services and programs vary across the state. MCPs play a critical role in coordinating services in their regions and to do so effectively requires an understanding of resources that are locally available.

- **In-Home Supportive Services (IHSS).** IHSS is a statewide Medi-Cal benefit that provides in-home assistance to eligible older, blind and disabled individuals as an alternative to out-of-home care. For members at risk for institutionalization/re-institutionalization and are being discharged home, or when a SNF resident is looking to transition to the community, IHSS are critical for ensuring members can successfully and safely remain living in their homes. Services may include house cleaning, personal care, meal preparation and accompaniment to medical appointments. MCPs and TCS care managers should refer and assess member eligibility for IHSS while planning for transitions out of a hospital or SNF, so they

would have adequate support to live independently in their own homes.[32] Members can receive support through the IHSS program and enroll in ECM.[33] Members are referred to IHSS through their county IHSS Office.[34]

Other Programs and Services:

- **California Community Transitions (CCT).** CCT is a statewide program funded through the Money Follows the Person federal demonstration that offers wraparound transition support to eligible Medi-Cal members who have continuously resided in state-licensed health care facilities for 60 days or longer. Upon transitioning to the community, a CCT transition coordinator (TC) follows and the supports the member for one year while the member lives in their home or in approved community care facilities. Meanwhile, the member receives LTSS included in their individual comprehensive service plan. For members that have or will reside in SNFs for 60 days or longer who are transitioning to the community, MCPs and the assigned TCS care manager could consider referring members to CCT for this comprehensive and longitudinal transition support. DHCS works with designated CCT LOs to identify eligible individuals for CCT.[35] LOs employ or contract with TCs to connect CCT participants with needed community-based services. The LO builds relationships and collaborates with facilities, MCPs and other service providers to ensure the Participant's safe and sustainable transition to the community, which may include handoffs to IHSS Social Workers, MCPs, HCBS Case Managers or other points of contact. Members cannot be concurrently enrolled in both CCT and ECM because both programs offer comprehensive care management.[36] For overlap policy between CCT and existing HCBS programs, please refer to Money Follows the Person

[32] Individuals can serve as a IHSS care provider to a family member or close friend. Learn more about becoming an IHSS provider at the California Department of Social Services (CDSS) website.
[33] ECM POF Spotlight for Long Term Care Populations (p. 7–9).
[34] DHCS has released a template Memorandum of Understanding (MOU) to support data exchange and communication between MCPs and IHSS servicers.
[35] California Department of Health Care Services. "Money Follows the Person Rebalancing Demonstration: California Community Transitions Operational Protocol 1.5." February 2017.
[36] ECM POF Spotlight for Long Term Care Populations (p. 7–9).

Rebalancing Demonstration: California Community Transitions Operational Protocol 1.5.[37]

- **Program for All-Inclusive Care for the Elderly (PACE).** In select counties, a PACE organization listing can be found in this Health Plan Directory. PACE uses an interdisciplinary team approach in a PACE Center and offers care management services, all needed preventive, primary, acute and LTC services for older adults who would otherwise reside in nursing facilities in a coordinated delivery system. The goal is to enable older adults to remain living in their community. To be eligible, a person must be aged 55 years or older, reside in a PACE service area, be determined eligible at the nursing home LOC, and be able to live safely in their home or community at the time of enrollment. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.[38] MCPs and TCS care managers may consider refer eligible members to their local PACE organization while planning for SNF discharges, so they can schedule a home visit, PACE site tour and medical assessment to confirm PACE eligibility. Members can be enrolled in a PACE program **or** ECM, but because both offer comprehensive care management, a member cannot enroll in both at the same time.[39]

1915(c) Waiver Programs

- **1915(c) HCBS Waiver Programs.** HCBS Waiver Programs provide services aimed at serving individuals who would otherwise qualify for institutional care in community-based settings. These programs are not uniformly available statewide, the eligibility criteria varies for each program and there may be waiting lists. Members can be enrolled in a 1915(c) waiver program **or** ECM, but because both offer comprehensive care management, a member cannot enroll in both at the same time.[40] For members being discharged from hospitals or SNFs, MCPs and TCS care managers could consider referring and assessing member eligibility for the following waiver programs to ensure robust support is in place for

[37] California Department of Health Care Services. "Money Follows the Person Rebalancing Demonstration: California Community Transitions Operational Protocol 1.5." February 2017.
[38] CMS Fact Sheet on PACE.
[39] ECM POF Spotlight for Long Term Care Populations (p. 7-9).
[40] ECM POF Spotlight for Long Term Care Populations (p. 7-9).

members to successfully transition and reside in an alternative setting or in the community:

- **Assisted Living Waiver (ALW)** (available in 15 counties): Care for members in residential care facilities, including RCFEs and ARFs, as an alternative to a SNF. In addition to payment for the daily cost of care and services at the facility, every Waiver participant receives care coordination, to assist participants in gaining access to needed waiver and other state plan services, from a Care Coordination Agency.[41]
- **Home and Community Based Alternatives (HCBA) Waiver** (available statewide): Care management and services to support member's living in a community-based arrangement. Care management services are provided by a multidisciplinary CMT who coordinate Waiver and state plan services (e.g., medical, behavioral health, IHSS) and arrange for other available LTSS available in the local community.[42]
- **Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) Waiver[43]:** Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private, nonprofit corporations known as regional centers. The regional centers are community-based nonprofit corporations that coordinate and/or provide community-based services to eligible individuals. The California Department of Developmental Services administers waiver which makes it possible for consumers to live in the community instead of an Intermediate Care Facility for the developmentally disabled (DD) or a State Developmental Center. The DD Waiver is currently the largest HCBS Waiver in California as well as the nation.
- **Multipurpose Senior Services Program (MSSP) Waiver** (available in 47 counties): Provides HCBS to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. MSSP care management includes: assessment, care planning, service

[41] Assisted Living Waiver – Appendix C - Summary of Services Covered.
[42] Home and Community-Based Alternatives Waiver; 2023-2027 HCBA Waiver: Appendix C-1/C-3: Participant Services – Service Specifications.
[43] HCBS-DD Approval Letter.

arrangement, Waiver Participant monitoring and purchased Waiver Services.[44, 45] Each MSSP site uses a team consisting of a Social Work Care Manager and a Nurse Care Manager to directly provide care management.

- **Medi-Cal Waiver Program (MCWP, formerly AIDS Waiver Program)** (available in 26 counties)**:** Provides comprehensive case management and direct care services to persons living with HIV/AIDS in a community-based arrangement as an alternative to nursing facility care or hospitalization.

[44] MMSP Waiver Application – 2. Brief Waiver Description.
[45] MSSP sites' staff purchase the Waiver Services through written agreements with local vendors.

APPENDIX 3: KEY TERMINOLOGY

- **Admission, discharge, and transfer (ADT) feed** is a standardized, real-time data feed sourced from a health facility, such as a hospital, that includes members' demographic and health care encounter data at time of admission, discharge and/or transfer from the facility.
- **Enhanced Care Management (ECM)** is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of high-cost and/or high-need members who meet ECM POF eligibility criteria through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch and person-centered.
- **Long- Term Care (LTC)** includes specialized rehabilitative services and care provided in a SNF, subacute facility, pediatric subacute facility, or Intermediate Care Facilities (ICFs).[46]
- **Long-Term Services & Supports (LTSS)** means services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the member's choice, which may include the member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS programs and includes carved-in and carved-out services.
- **Population Health Management (PHM)** is a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
- **Transitional Care Services (TCS)** are services provided to all members transferring from one institutional care setting or LOC to another institution or lower LOC (including home settings).

[46] 2024 Medi-Cal Managed Care Plan Contract. Exhibit A, Attachment I, Definitions and Acronyms.

APPENDIX 4: HPSM COMMUNITY PLACEMENT READINESS SCREENING FORM EXAMPLE

Please review this example that HPSM uses to screen members to Community Supports NF Transition Services or ECM.

Member Information

Name:	Age:	Admission Date:
Date of Birth:	Referral Date:	Prim. Language:
Facility:	Line of Business:	HPSM ID or CIN:

CRITERIA ITEMS (all must apply)	COMMENTS
Community Placement Readiness ☐ Interested to transition to community ☐ SNF resident at least 60 days ☐ Has cognitive & decision-making capacity or has legal decision maker ☐ Has or is able to secure caregiver support or eligible for IHSS hours	
Care Management ☐ Willing to accept care management services ☐ Needs intensive care management in order to maintain health & medical care in the community ☐ Willing to participate in assessment & care planning	
Current ADL/IADLs ☐ Has ADL and/or IADL needs that can be managed in the community with IHSS or caregiver support and improved functional status while in SNF	
HPSM Member ☐ Active Medi-Cal ☐ Active CareAdvantage	

Exclusions: ECM is a Medi-Cal benefit; CareAdvantage members do not qualify.

APPENDIX 5: MCP CONTACT INFORMATION

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