Population Health Management (PHM) Program:
Transitional Care Services Policy

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

January 22, 2024

Today's Agenda

- Overview of Transitional Care Services within Population Health Management Program
- Phased TCS Requirements Effective since 1/1/23
- Updated TCS Requirements Effective 1/1/24
- Upcoming Activities for TCS
- Q&A

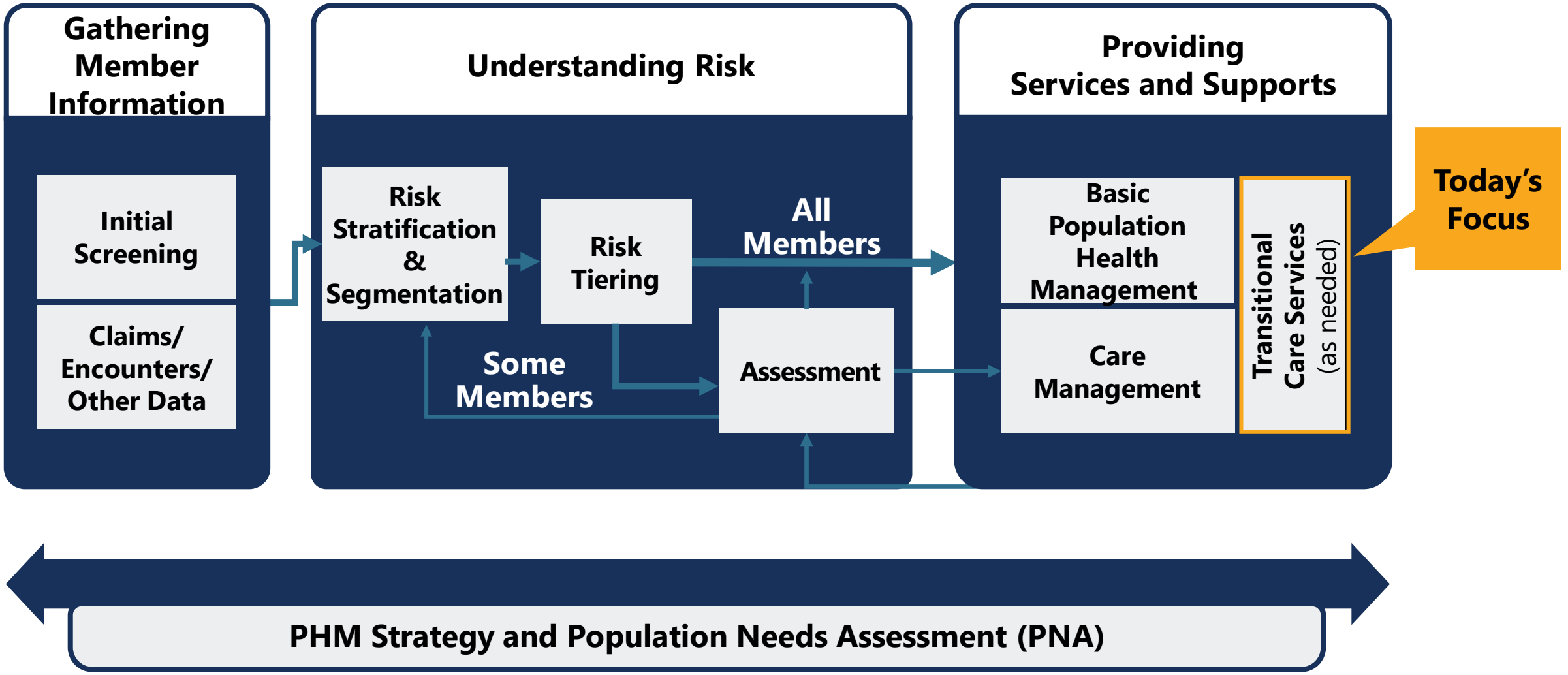
Population Health Management (PHM)

Medi-Cal's Transformation establishes a cohesive, statewide approach to PHM that ensures all members have access to a comprehensive program that leads to longer, healthier lives, improved outcomes, and health equity.

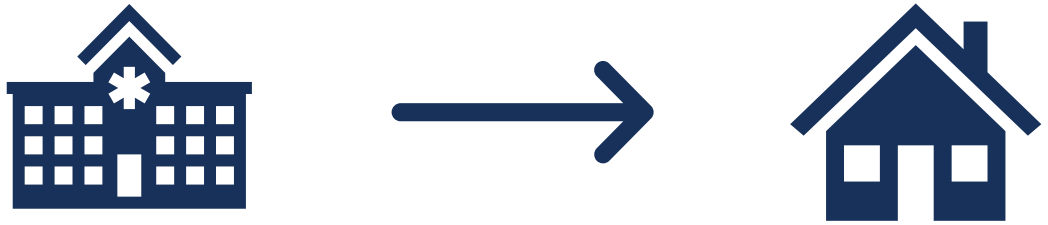
PHM is a comprehensive, accountable plan of action that:

- Builds trust and meaningfully engages with members.
- Gathers, shares, and assesses timely and accurate data on member preferences and needs to identify effective benefits and services.
- Connects members to preventive care and other care management and transitional care services.
- Reduces health disparities by linking members to public health and social services that address their health-related social needs.

PHM Program Framework



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.

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.**

TCS Requirements for All Members

(Effective 1/1/24)

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 All Members

- 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**

Difference between TCS for High- vs. Lower-Risk Members

- For high-risk members, MCP must ensure the Member has a **single point of contact** who proactively support members for the duration of the transition.
- For lower-risk members MCPs must ensure a **dedicated team/phone number** will be available to members to support them as needed.

TCS for both high- and lower-risk members focuses on **ensuring necessary follow ups (e.g., ambulatory or PCP visits) are completed**, for necessary post-discharge care and services, including medication reconciliation.

Ensuring that Members transition to the least restrictive level of care that meets their needs and aligns with their preferences is a cornerstone of TCS.

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** The TCS team must be able to access discharge planning information as necessary to support members.	MCP/ Delegate
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

DHCS Support for TCS Implementation

To ensure effective TCS implementation on the ground, DHCS is engaging with various stakeholder groups and providing technical assistance through multiple channels.

Engagement to Date

- Conducted a stakeholder survey to solicit feedback on implementation of TCS
- Revised and published updated TCS policy to reflect stakeholder feedback
- Convened stakeholder engagement calls with associations representing hospitals, skilled nursing facilities, and primary care providers

These stakeholder engagement calls have elevated examples of innovative practices that are making a difference for TCS on the ground

- E.g., effective sharing of care manager information via eligibility file with hospitals (Central California Alliance for Health), ensuring strong discharge info sharing with hospitals on ECM provider and members' PCP (CenCal Health)

Technical assistance on TCS will be ongoing.

DHCS is interested in learning about ways that TCS is implemented well for members experiencing transitions of care.

- What are some lessons learned?
- Any promising TCS practices, or good outcomes you see happening on the ground?