Policy:	GG.1357
Title:	**Population Health Management Transitional Care Services (TCS)**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 09/18/2024*
Effective Date:	01/01/2023
Revised Date:	09/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima Health's Transitional Care Services (TCS) and describes the process by which CalOptima Health, Health Networks, and Providers engage Members across all settings and delivery systems, ensuring Members are supported from discharge planning until they have been successfully connected to all needed services and supports.

Care Transitions are defined as a Member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings. This includes critical TCS tasks, such as ensuring that medication reconciliation is completed upon discharge by the discharging Facility, and that every member has follow-up care by a Provider, including another medication reconciliation completed post-discharge to reduce medication discrepancies, errors, and adverse drug events that are common and can lead to poor outcomes in transitions.

II. POLICY

A. CalOptima Health shall establish and maintain a Population Health Management (PHM) Program in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program and CalOptima Health Policy GG.1667: CalAIM Population Health Management Program.

1. The PHM Program ensures that all Members have access to a comprehensive set of services based on their individual needs and preferences across the continuum of care, which promotes improved outcomes, and Health Equity.

2. The PHM Program includes Basic Population Health Management (BPHM), Care Management, Complex Care Management (CCM), Enhanced Care Management (ECM), and TCS.

    a. TCS shall be provided for High-Risk Members, along with Members enrolled in Case Management or ECM through a single point of contact responsible for providing Longitudinal Support and ensuring all required services are complete which may be the

TCS Assigned Care Manager; the ECM Lead Care Manager (LCM) for members enrolled in ECM; or the CCM Care Manager for members enrolled in Case Management.

b. TCS shall be provided for non-High-Risk Members.

c. TCS shall be provided to Members in ICF/DD Homes, in accordance with CalOptima Health Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N.

B. Under the PHM Program and in line with CalAIM initiatives, CalOptima Health shall fully implement TCS for all Members by January 1, 2024.

C. Members who are dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA Plans (except D-SNPS), CalOptima Health is responsible for all TCS requirements.

D. If a Member has an existing CCM Care Manager or ECM LCM, CalOptima Health or a Health Network is responsible for notifying the CCM Care Manager or ECM LCM of the Admission, Discharge, and Transfer (ADT).

E. Transitional Care Services (TCS) requirements build on existing requirements for discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation, national Joint Commission accreditation standards, state statutory requirements, and certain similar requirements apply to SNFs including but not limited to CoPs requirements set forth in federal regulations .

F. CalOptima Health and its Health Networks shall take an incremental approach to the provision of TCS services and continually strengthen the process to ensure Member-centered care. TCS is being rolled out in collaboration with CalOptima Health and its Health Network contracted Facility partners to ensure alignment and avoid duplication.

III. PROCEDURE

A. CalOptima Health and its Health Networks shall ensure provision of all TCS in collaboration and partnership with discharging Facilities, including provision of discharge planning as required by federal and state requirements.

B. CalOptima Health and its Health Networks must ensure discharging facilities complete a discharge planning process that provides patient-centered discharge planning as follows:

1. Engages Members and/or Members' caregivers as appropriate, when being discharged from a hospital, institution, or Facility.

2. Focuses on the Member's goals and treatment preferences during the discharge process, and ensures documentation in the Member's Medical Record.

3. Uses a consistent assessment process and/or assessment tools to identify Members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning.

a. For High-Risk Members, CalOptima Health and its Health Networks shall ensure the discharging Facility shares this information with the assigned Care Manager and that the discharging Facilities have processes in place to refer to members to ECM or Community Supports, as needed.

b. For Members not identified as high-risk, the discharging Facility must have processes in place to leverage the assessment to identify Members who may benefit from High-Risk Member TCS services. This process must include Referrals for:

i. Any Member who has a specialty mental health need or substance use disorder.

ii. Any Member who is eligible for an ECM Population of Focus.

iii. Any Member whom the clinical team feels is high risk and may benefit from more intensive transitional care support upon discharge.

4. Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and timely Referrals.

5. Ensures Members and their caregiver(s) are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner including but not limited to:

a. Medication reconciliation upon discharge that includes education and counseling about the Member's medications.

6. Coordinates care with:

a. The Member's designated family caregiver(s) including but not limited to:

i. Notification of the Member's discharge or transfer to another Facility.

b. Post-discharge Providers for notification and receipt of necessary clinical information, including but not limited to:

i. A discharge summary in the Medical Record that outlines the care;

ii. Treatment and services provided;

iii. The patient's condition and disposition at discharge; and

iv. Information provided to the patient and family and provisions for follow-up care.

C. Transitional Care Services (TCS) for High-Risk Members.

1. CalOptima Health and its Health Networks shall provide TCS for Members transferring from one setting or level of care to another, including but not limited to: discharges from hospitals, institutions, other acute facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports, post-acute care facilities, or Long-Term Care (LTC) settings.

a. As part of the TCS process, CalOptima Health and its Health Networks shall identify a TCS Assigned Care Manager as a single point of contact for TCS High-Risk Members to ensure completion of TCS in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.

b. The provision of TCS is provided through the TCS Assigned Care Manager; the ECM LCM for Members enrolled in ECM; or the CCM Care Manager for Members enrolled in Case Management.

2. CalOptima Health and its Health Networks shall communicate with the Facility where the Member is admitted so the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager can participate in discharge planning and support access to available services.

3. CalOptima Health and its Health Networks shall offer Members direct assistance of the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager; however, Members may choose to have limited contact or decline contact with the Care Manager, in accordance with the DHCS CalAIM: Population Health Management (PHM) Policy Guide.

    a. In these cases, at a minimum, the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager must act as a liaison coordinating care among the discharging Facility, the Primary Care Practitioner (PCP), and CalOptima Health or Health Networks.

4. CalOptima Health shall ensure the TCS Assigned Care Managers, ECM LCM, or CCM Care Manager are notified within twenty-four (24) hours of admission, transfer, or discharge through an ADT Feed notification or within twenty-four (24) hours of being made aware of an admission, transfer, or discharge when an ADT Feed is not available.

5. CalOptima Health or a Health Network and the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager is responsible for coordinating and verifying that Members receive all appropriate TCS, regardless of setting.

6. CalOptima Health and Health Networks shall ensure Prior Authorizations required for a Member's discharge; and, for Medi-Cal benefits where Medi-Cal is the primary payor are processed in a timely manner, in accordance with CalOptima Health Policy GG.1508 Authorization and Processing of Referrals.

7. CalOptima Health or Health Networks and the TCS Assigned Care Managers, ECM LCM, or CCM Care Manager shall collaborate with the Facility on the discharge risk assessment and planning document for High-Risk Members

8. Hospital Discharged Members High Risk

    a. CalOptima Health and its Health Networks will outreach, and triage Members based on risk and Care Coordination needs.

        i. CalOptima Health enhanced data identification processes are utilized to identify High-Risk Members.

        ii. High-Risk identified Member data is shared on a monthly basis with the Health Networks.

    b. The TCS Assigned Care Manager, ECM LCM or CCM Care Manager shall ensure needed post-discharge services are provided and Referrals are made, follow-ups are scheduled and completed, including, but not limited to:

        i. Assisting with making follow up Provider appointments, to occur within seven (7) days post-discharge;

        ii. Connecting to the PCP (if PCP has changed); and

        iii. Arranging transportation, in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

iv. Substance Use Disorder, (SUD) and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition;

v. Medication reconciliation, post discharge;

vi. Completion of Referrals to social service organizations, and Referrals to necessary at-home services (DME, home health, etc.);

vii. Connection to Community Supports as needed; and

viii. Members transitioning to or from nursing facilities.

9. End of TCS Services for High-Risk Members.

a. TCS shall end once the Member has been connected to all needed services including but not limited to all services that are identified in the discharge risk assessment or discharge planning document, and extend at minimum for thirty (30) calendar days post-discharge.

b. Members with ongoing Care Coordination needs shall be assessed and referred for ECM or CCM services as appropriate.

c. CalOptima Health or a Health network will ensure Members with multiple Care Transitions within a thirty (30) day period have the same TCS Assigned Care Manager, ECM LCM, or CCM Care Manager assigned to support them through the transitions.

d. For a Member who does not respond to outreach attempts or did not attend scheduled follow-up ambulatory visits, CalOptima Health or a Health network must make reasonable effort to ensure engagement and follow-up ambulatory visits are completed which may include but not limited to use of Community Health Workers (CHWs)

e. If a second transition is within seven (7) calendar days of the first transition, then the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager must ensure the follow up visit is completed within seven (7) calendar days post discharge after the last transition and continue to provide support for at least thirty (30) calendar days.

D. Transitional Care Services for non-High-Risk Members effective January 1, 2024

1. CalOptima Health or a Health Network shall ensure lower-risk Members have access to the following for at least thirty (30) calendar days from discharge:

a. Have access to a dedicated TCS team;

b. Have access to a dedicated telephonic support services with a live team; and

c. Post-discharge Ambulatory follow up:

i. Encourage that Member completes follow up ambulatory visit with Provider within thirty (30) calendar days of discharge.

E. CalOptima Health and delegated Health Networks will use data including any information from admission, to identify newly qualified Members for outreach and enrollment into ECM, CCM, and/or Community Supports.

F. CalOptima Health shall ensure delegated Health Networks follow and coordinate services.

G. CalOptima Health is responsible for all TCS requirements for Members who are dually eligible for Medi-Cal and Medicare enrolled in Medicare FFS or MA Plans (except D-SNPS).

H. Behavioral Health services are provided for Members in accordance with CalOptima Health Policy GG.1900: Behavioral Health Services.

1. CalOptima Health and its Health Networks will be responsible for providing TCS services for Members admitted when the Orange County Health Care Agency (OCHCA) Orange County Mental Health Plan (OCMHP) is not the primary payor.

I. TCS services for Members residing in Long Term Care (LTC) are provided in accordance with CalOptima Health Policy GG.1800: Authorization Process, and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B), GG.1803: Authorization Process, and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility – Adult/Pediatric, and GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Nursing Facility Level A (NF-A) and Level B (NF-B).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
C. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
E. CalOptima Health Policy GG.1800: Authorization Process, and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
F. CalOptima Health Policy GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from an ICF/DD, ICF/DD-H, and ICF/DD-N
G. CalOptima Health Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility – Adult/Pediatric
H. CalOptima Health Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
I. CalOptima Health Policy GG.1900: Behavioral Health Services
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)
K. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, May 2024

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/15/2023	Department of Health Care Services (DHCS)	Approved as Submitted
09/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
02/01/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2023	GG.1357	Population Health Management Transitional Care Services (TCS)	Medi-Cal
Revised	09/01/2024	GG.1357	Population Health Management Transitional Care Services (TCS)	Medi-Cal

IX. GLOSSARY

Term	Definition
Admission, Discharge, and Transfer (ADT) Feed	A standardized, real-time data feed sourced from a health facility, such as a hospital, that includes Members' demographic and healthcare encounter data at time of admission, discharge, and/or transfer from the facility.
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each Member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Care Manager	An individual identified as a single point of contact responsible for the provision of care management services for a Member.
Care Transitions	A Member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and Skilled Nursing Facilities (SNFs) to home- or community-based settings, Community Supports placements (including sobering centers, recuperative care and short-term post hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Complex Case Management (CCM)	An approach to care management that meets differing needs of high and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statue and/or regulation.

Term	Definition
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit
Enhanced Care Management (ECM) Lead Care Manager	A Member's designated Enhanced Care Management (ECM) care manager who works for the ECM Provider organization or as staff of CalOptima Health and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.
Facility	Any premise that is: 1. Owned, leased, used or operated directly or indirectly by or for CalOptima Health for purposes related in the DHCS Medi-Cal Contract; or 2. Maintained by a Provider to provide services on behalf of CalOptima Health.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network
High-Risk Members	For purposes of this policy Members which include: 1. Those with Long-Term Services and Supports (LTSS) needs (as required by federal and state law and waiver); 2. Those entering Complex Care Management (CCM) (per NCQA); 3. Those entering Enhanced Care Management (ECM); 4. Children with Special Health Care Needs (CSHCN); 5. Pregnant individuals; and 6. Seniors or Persons with Disabilities who meet the definition of "high risk" as established in existing APL requirements, namely: a. Members who have been authorized to receive: i. In-Home Supportive Services (IHSS) greater than, or equal to, one-hundred and ninety-five (195) hours per month; ii. Community-Based Adult Services (CBAS); and/or iii. Multipurpose Senior Services Program (MSSP) Services. b. Members who: i. Have been on oxygen within the past ninety (90) days; ii. Are residing in an acute hospital setting; iii. Have been hospitalized within the last ninety (90) days or have had three (3) or more hospitalizations within the past year; iv. Have had three (3) or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases); v. Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness); vi. Have end-stage renal disease, Acquired Immunodeficiency Syndrome (AIDS), and/or a recent organ transplant;

Term	Definition
	vii. Have cancer and are currently being treated; viii. Are pregnant; ix. Have been prescribed antipsychotic medication within the past ninety (90) days; x. Have been prescribed fifteen (15) or more prescriptions in the past ninety (90) days; xi. Have a self-report of a deteriorating condition; xii. Have other conditions as determined by the MCP, based on local resources. xiii. Any member who has been served by county SMHS and/or DMC or DMC-ODS (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by the MCP or discharging facility; xiv. Any member transitioning to or from a SNF; xv. Any member that is identified as high risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS.
Longitudinal Support	A single relationship must span the whole transition.
Long Term Care (LTC)	Specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes.
Medical Record	The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Population Health Management	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.
Population of Focus	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Individuals At Risk for Avoidable Hospital or emergency department utilization; c. Adults with Serious Mental Illness (SMI) and/or substance use disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; g. Birth Equity Population of Focus

Term	Definition
	2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. Individuals At Risk for Avoidable Hospital or emergency department utilization; c. Children (up to age 21) with Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD); d. Individuals transitioning from incarceration; e. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; f. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and g. Birth Equity Population of Focus Transitioning from incarceration.
Primary Care Practitioner/Physician (PCP)	A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Referral	The process of a Provider directing a Member to another Provider for care and or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Skilled Nursing Facility (SNF)	As defined in Title 22 CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home," or "nursing facility."
Transitional Care Services (TCS)	Services provided to all Members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).
Transitional Care Services (TCS) Assigned Care Manager	For purposes of this policy, defined as the single point of contact responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.