PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2034</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Transitional Care Services (TCS)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/12/2024
Effective Date: 01/01/2023</td><td colspan="4">Next Review Date: 06/12/2025
Last Review Date: 06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 06/12/2024</td></tr>
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I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MCCP2007 – Complex Case Management
D. MCCP2032 – CalAIM: Enhanced Care Management (ECM)
E. MCUP3142 – CalAIM Community Supports (CS)
F. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
G. MCND9001 – Population Health Management Strategy & Program Description
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MPUD3001 – Utilization Management Program Description
J. MCUP3106 – Waiver Programs
K. MCUG3011 – Criteria for Home Health Services
L. MCUP3028 – Mental Health Services
M. MCUP3101 – Screening and Treatment for Substance Use Disorders
N. MCUP3013 – Durable Medical Equipment (DME) Authorization
O. MCUP3064 – Communications Services
P. MCCP2018 – Advice Nurse Program
Q. MCCP2033 – Community Health Worker (CHW) Services Benefit

II. IMPACTED DEPTS:

A. Health Services
B. Behavioral Health
C. Claims
D. Member Services
E. Provider Relations

III. DEFINITIONS:

A. Accountable Care Organizations (ACO): These are groups of hospitals, doctors, and other health care providers that come together voluntarily to provide coordinated high-quality care to assigned groups of patients.
B. Admission, Discharge, and Transfer (ADT) data: Feeds for timely notification of member needs at time of hospital discharge, and reducing inefficiencies by sharing member information in standard formats.
C. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The

frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

D. PointClickCare (PCC) formerly Collective Medical Technologies (CMT): A contracted external vendor platform designated as Partnership HealthPlan of California (Partnership)'s data sharing and information exchange system. This platform allows Partnership's Care Coordination staff or other member-facing teams to collaborate with community partners and external case management leads without duplicating services.

E. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

F. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

G. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

H. Complex Case Management (CCM): The process of applying evidence-based practices to individual members to assist them with the coordination of their care and promote their well-being.

I. Drug Medi-Cal Organized Delivery System (DMC-ODS): An opt-in 1115 waiver program available in California since 2015 that provides the opportunity for counties to expand substance use treatment options outside of traditional Medicaid substance use treatment offerings. In the DMC-ODS, opted-in counties provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services which enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use treatment, and coordinates with other systems of care. Of Partnership's 24 counties, 7 participate in Partnership's Regional DMC-ODS program (aka as Partnership's "Wellness and Recovery Program" see III.Q.): Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. Five other counties have organized their own county-managed DMC-ODS programs (over which Partnership has no regulatory oversight responsibilities): Marin, Napa, Nevada, Placer, and Yolo counties. The remaining counties have not opted into the DMC-ODS program and therefore abide by the county-managed "State Plan" DMC program.

J. 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.

K. Longitudinal Support: This means that a single relationship must span the whole transition.

L. Long-Term Services & Supports (LTSS): These include 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, and includes carved-in and carved-out services.

M. Population Health Management (PHM) Service: A State-wide service that collects and links Medi-Cal beneficiary information from disparate sources and performs risk stratification and segmentation (RSS) and risk-tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multiparty data access and use in accordance with state and federal law and policy.

N. Risk Stratification and Segmentation (RSS)**:** Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process leverages data from multiple data sources to separate its member populations into different risk groups and/or meaningful subsets using information collected through a proprietary algorithm and other data sources that include population and member assessments, demographic data, and utilization data. Partnership's RSS results in the categorization of members with care needs at all levels and intensities. When available, Partnership will also incorporate the standardized risk tier criteria provided through DHCS's PHM Service (defined in III.M. above), which will include a single, statewide, open-source RSS methodology for risk stratification that will place all Medi-Cal members into high, medium-rising, and low-risk tiers.

O. Specialty Mental Health Services (SMHS): aka Serious and Persistent Mental Health Services County Mental Health Plans (MHPs) are contractually required to provide or arrange for the provision of SMHS for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073.

P. Transitional Care Services (TCS): A set of activities and interventions provided to members transferring from one institutional care setting or level of care to another institution or lower level of care, including home settings.

Q. TCS Care Manager: Regardless of organizational setting or job title, an individual who shall serve as the identified single point of contact who is responsible for the provision of transitional care services for a member.

R. Wellness & Recovery Program (W&R): Partnership's regional Drug Medi-Cal Organized Delivery System waivered program in seven counties within Partnership's service area.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe and define Partnership HealthPlan of California (Partnership's) Transitional Care Services (TCS) as required by the DHCS Population Health Management (PHM) Policy Guide. This policy shall also outline the collaboration between Partnership's Health Services staff, provider network, and members to ensure safe, effective, quality coordination of care and planning across health care settings.

This policy was written based on the request by DHCS as part of their PHM Policy Guide. Full implementation of the activities and requirements outlined in this policy are on pause until DHCS provides finalized guidance to Partnership on the funding source for these activities and has indicated they have finalized the PHM Policy Guide as it relates to TCS activities.

VI. POLICY / PROCEDURE:

A. Transitional Care Services (TCS):

1. Partnership shall ensure Transitional Care Services are provided to Members transferring from one

setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and state laws and regulations, and DHCS guidance. Settings include, but are not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports (CS) placements (including Sobering Centers, Recuperative Care, and Short-Term Post Hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings. Across these settings, TCS shall prioritize member-centered care by:

a. Ensuring members are supported with discharge planning until they have been successfully connected to all needed services and supports.
b. Ensuring that a single point of contact, herein referred to as a TCS care manager, can assist throughout all high-risk members' transitions, providing longitudinal support, and ensuring all required services are completed.
c. Ensuring that a dedicated TCS Team and a phone number is available to support lower-risk transitioning members telephonically when needed.
d. Ensuring members receive timely follow-up care after emergency department (ED) visits for mental health or Substance Use Disorder (SUD) issues.
e. Ensuring members receive timely follow-up after ED visits for pregnant and postpartum individuals (through 12 months postpartum), given the association of ED visits and maternal morbidity and mortality.

B. Transitional Care Services shall include the following:
1. Ensuring collaboration and partnership with discharging facilities, including ensuring hospitals provide patient-centered discharge planning as required by federal and state requirements. Partnership must ensure discharging facilities complete a discharge planning process that:
    a. Engages the member/caregiver(s)/legal guardian/authorized representative, as appropriate, when being discharged from a hospital, institution, or facility.
    b. Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
    c. 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, in alignment with hospitals' current processes. Hospitals are currently required to identify these members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.
        1) For high-risk members, Partnership must ensure the discharging facility shares this information with Partnership's TCS care manager and that the discharging facilities have processes in place to refer to members to Enhanced Care Management (ECM) or CS, as needed.
        2) For members not already classified as high risk by Partnership per Section VI.C.1, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to Partnership for:
            a) Any member who has a special mental health need or SUD.
            b) Any member who is eligible for an ECM Population of Focus
            c) Any member whom the clinical team feels is high risk and may benefit from more intensive transitional care support upon discharge.
    d. Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.
2. As defined above in Section III.C, closed loop referrals to CS and/or coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS), Long Term Support

Services (LTSS) and/or Home and Community Based Waiver (HCBS) services and programs.

3. Ensuring that medication reconciliation is conducted pre- and post-transition that includes education and counseling about the member's medications.
4. Ensuring all necessary prior authorizations required for a member's discharge are completed in timeframes consistent with the member's condition and regulatory requirements. Examples include, but are not limited to, authorizations for:
    a. Therapy
    b. Home care / Home Health
    c. Medical supplies
    d. Prescription medications
    e. Durable Medical Equipment (DME)
5. Coordination to ensure appropriate post-discharge appointment attendance and follow up as follows:
    a. Ensure the post-discharge providers are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
    b. Confirm hospital has secured necessary follow-up appointments prior to discharge
    c. Assist with scheduling/arranging transportation when necessary for follow-up appointments
    d. Ensure needed post-discharge services are provided and follow-up visits are scheduled, including, but not limited to, follow-up provider appointments, SUD and/or mental health treatment initiation
6. Follow-up with member and/or their guardian/caregiver/legal representative/authorized representative to ensure that services are coordinated and post-discharge needs have been met.
7. Members may choose to have limited to no contact with the identified TCS care manager. In these cases, at a minimum, the TCS care manager must act as a liaison coordinating care among the discharging facility, the primary care provider (PCP), and Partnership.
8. Coordination and verification that the member is receiving all appropriate services regardless of setting.
9. Ensuring collaboration, communication and coordination with the member, their caregiver(s)/guardian/authorized representative and the care team including, but not limited to, hospitals, physicians (including the member's PCP), LTSS providers, discharge planners, social workers, and/or other case managers to ensure and facilitate a safe and successful transition.
10. A core responsibility of the care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member and to ensure the member participates in the care plan and receives and understands information about their needed care. To do this, the care manager must complete the following:
    a. Risk Assessment: The TCS care manager must assess member's risk for adverse outcomes to inform needed TCS. This must include, reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The TCS care manager may supplement this risk assessment as needed through member engagement. During this process, the care manager must also identify members who may be newly eligible for ongoing care management (ECM/CCM), and/or Community Supports and make appropriate referrals.
    b. Discharge Instructions: The TCS care manager must receive and review a copy of the discharging facility's discharge instructions given to the member, including the medication reconciliation completed upon discharge by the discharging facility. After discharge, upon member engagement, the TCS care manager must review the discharge instructions with the member and ensure that member can have any questions answered. A best practice (not required) is for the TCS care manager to work with the facility to ensure that the TCS care

manager's name and contact information are integrated into the discharge documents.

c. Discharge Summary and Clinical Information Sharing: The TCS Care Managers must receive and review a copy of the discharging facility's discharge summary once it is complete. The TCS Care Managers must ensure all follow-up providers have access to the needed clinical information from the discharging facility, including the discharge summary.
d. Preadmission status which includes living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission
e. Pre-discharge support needs which include the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge
f. Discharge location, which is the hospital, institution, or facility to which the member was admitted
g. Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences
h. Specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling
i. Summary of the nature and outcome of participation of the member/caregiver(s)/legal guardian/authorized representative in the discharge planning process
j. Anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution or facility to be included in the Member's Medical Record
k. Information regarding available care, services, and supports that are in the member's community once the member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the member.
l. TCS Care manager's name and contact information and a description of TCS should also be included

11. Ensures that the Discharge Planning Document shall use language that is culturally, linguistically and literacy-level appropriate, and be shared with the member, their caregiver(s)/legal guardian/authorized representative, treating providers, primary care providers, discharging facility and the receiving provider.

C. TCS Member Eligibility & Identification:
1. As part of Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process, Partnership members shall be proactively identified for TCS services.
a. Pursuant to the DHCS Population Health Management (PHM) policy guide, Partnership members identified as 'high risk' must be offered TCS services beginning January 1, 2023. Partnership must offer support for TCS for lower-risk transitioning members effective January 1, 2024.
b. For more information on Partnership's Population Health Management Program and/or Risk Stratification/Segmentation process, see Partnership policy MCND9001 Population Health Management Strategy & Program Description.
c. High-risk transitioning members means all member that meets criteria under MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1 and other members assessed as high risk by RSS and Risk Tier Process. Noting for TCS purposes, pregnant individuals include individuals hospitalized during pregnancy, admitted during the 12-month period post-partum, and discharges related to the delivery.
d. In addition to these groups, and in recognition of high risk of poor outcomes in transition for Partnership members enrolled in multiple payors, those transitioning from SNFs, and those at high risk who are potentially not captured in criteria mentioned in section VI.C.1.c, Partnership

must also consider the following members high-risk for the purpose of TCS:

1) Any member who has been served by county Special Mental Health Services (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 Partnership or discharging facility
2) Any member transitioning to or from a SNF
3) 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

e. Lower-risk transition members are defined as those not included in the high-risk transitioning members noted above.

2. Partnership utilizes Admission, Discharge and Transfer (ADT) data feeds to assist in member identification for TCS services and for assistance with timely authorizations for services that require prior authorization (e.g. acute in-patient care setting requests, etc.).
3. Partnership utilizes the ADT feed, PointClickCare (PCC) formerly Collective Medical Technologies (CMT), to receive timely notifications within 24 hours of a member's admission, transfer or discharge.
    a. When ADT feeds are not available, Partnership shall utilize other mechanisms to identify members who may be eligible for TCS. This includes but is not limited to: fax notifications from facilities/institutions, Treatment Authorization Requests (TAR) for services, existing data-sharing agreements with providers/vendors, direct referrals to the Health Services department, and/or internal reports. Notification is necessary within 24 hours of Partnership being aware of any planned admission, or of any admissions, discharges, or transfers. However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

D. TCS Care Manager, Care Manager Assignment, & TCS Team
1. Once a high-risk member has been admitted, Partnership shall identify a TCS care manager who shall serve as the single point of contact for the member to provide longitudinal support and who ensures completion of all TCS services outlined in section VI.A.
    a. For members enrolled in Partnership's Complex Case Management (CCM) program, the Partnership Case Manager shall serve as the TCS care manager and perform all TCS services for the member.
    b. For members enrolled in the ECM benefit, the ECM Lead Care Manager shall serve as the TCS care manager and perform all ECM services for the member. For more information regarding the ECM benefit, see Partnership Policy MCCP2032 CalAIM Enhanced Care Management (ECM).
2. For high-risk members identified for TCS, the member shall be referred to Partnership's CCM program or ECM benefit as appropriate.
3. For lower-risk members identified for TCS, Partnership is required:
    a. To ensure member has access to a specialized TCS Team (at Partnership or a delegate) for a period of at least 30 days from discharge.
    b. To ensure member can outreach to a dedicated telephonic support service. See Partnership Policy MCUP3046 Communication Services and MCCP2018 Advice Nurse Program for more details.
    c. To facilitate as needed members' ambulatory follow-up within 30 days of discharge for necessary post-discharge service.
4. For all other members identified for TCS, Partnership shall evaluate and identify an appropriate TCS care manager. Examples include, but are not limited to, Partnership Health Services staff, hospital staff, primary care providers, and/or other contracted agencies.
    a. Facility staff who help with discharge planning should work with, but not take the place of the

responsible TCS care manager, unless Partnership has formally assigned the facility to act as the TCS care manager.

5. The ADT notification platform, PCC formerly CMT, shall be used to notify the TCS case manager of the member's admission, discharge and/or transfer status including the location of admission and facility contact information.
6. Partnership will notify the discharging facility of the name and contact information, including phone number, of the identified TCS care manager in the discharge planning document.
7. Partnership will provide the TCS care manager's contact information to the member, member's parents, legal guardians, or authorized representative, as part of the discharge planning document.
8. The TCS case manager must obtain permission from the member, members' parents, legal guardians, or authorized representatives, as appropriate, to share information with providers to facilitate transitions, in accordance with federal and state privacy laws and regulations (ex: Release of Information (ROI), etc.)
9. The TCS care manager must also ensure non-duplication of services provided through other programs such as ECM, CCM, Targeted Case Management, etc.
10. The assigned TCS care manager shall ensure that all TCS are provided in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up and post discharge.
11. High-Risk Member Outreach: The identified TCS care manager is responsible for contacting the member within 7 days of discharge and supporting the member in all needed TCS care identified at discharge, as well as any new needs identified through engagement with the member or their care providers.
12. Low-Risk Member Outreach: Direct communication about the dedicated TCS team and phone line and how to access it. Partnership must make best efforts to ensure members receive this information no later than 24 hours after plans are notified of the discharge. Acceptable methods of communication include automated phone calls, incorporating into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). More than one method of notification can be utilized.

E. End of TCS
   1. High-Risk Members
      a. TCS will end once the member has been connected to needed services as identified in the discharge risk assessment or in the discharge planning document. TCS should extend at least 30 days post-discharge.
      b. If Partnership has delegated TCS to another contracted entity (e.g. hospital, PCP), Partnership will ensure that the delegate follows and coordinates services for the member until all aforementioned activities are completed. A monitoring plan would be in place to ensure all required TCS are completed.
         1) This arrangement for managed care plan (MCP) contracted entities to provide TCS is not considered formal delegation and therefore, Partnership is not subject to requirements outlined in APL 23-006 "Delegation and Subcontractor Network Certification."
      c. For those members who have ongoing unmet needs post-TCS, eligibility for ECM or CCM should be reconsidered.
      d. If the member is enrolled in ECM or CCM, and if the TCS care manager responsible for TCS will not continue as their ECM or CCM Lead Care Manager, the member should be connected to their new TCS care manager through a referral.
      e. For members who are unresponsive to Partnership's outreach attempts or did not attend scheduled follow-up ambulatory visits, Partnership must make reasonable effort to ensure members:
         1) Are aware that TCS support is available for at least 30 days.

2) Are engaged and that follow-up ambulatory visits are completed.

f. For members with multiple care transitions within a 30-day period, Partnership must ensure the same TCS care manager is assigned to support the member through all these transitions. If the second transition is within 7 days of the first transition, then the TCS care manager must facilitate as needed a follow up visit to be completed within 7-days post discharge after the last transition. The TCS care manager must also provide TCS support for at least 30 days after the last transition. These members should be considered for ECM/CCM and/or CS eligibility.

2. Lower-Risk Members
   a. Partnership must continue to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge.
   b. In addition to accepting referrals to longer term care management at any point during the transition, Partnership will use data including any information from admission, to identify newly qualified members for outreach and enrollment into ECM/CCM and/or CS.
3. Partnership may utilize Community Health Worker's (CHW's) when available through the CHW benefit to facilitate member outreach and engagement. Refer to Partnership policy MCCP2033 Community Health Worker (CHW) Services Benefit for details.

F. Prior Authorization and Timely Discharge
1. Partnership adheres to regulatory prior authorization processing timeframes. The timely processing of authorizations supports Partnership's contracted providers in discharge planning and ensuring necessary services and supports are in place prior to discharge. Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process describes how Partnership monitors performance and complies with regulatory prior authorization processing timeframes and standards as well as APL 21-011 "Grievance and Appeal Requirements, Notice and "Your Rights" Templates".
2. As described in Partnership policy MPUD3001 Utilization Management Program Description, members are evaluated for appropriateness of care setting pursuant to medical necessity and the documented discharge plan. The discharge plan shall take into account the continuing care needs and initiation of arrangements for services or placement needed after discharge.
   a. Partnership shall collaborate with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.
3. To support effective discharge planning practices, Partnership shall ensure all network providers (e.g. hospitals, acute care facilities, institutions, etc.) educate their discharge staff on the services, supplies, medications, and DME that require a Treatment Authorization Request (TAR). A list of items that require prior authorization is attached to Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process as Attachment A. The policy is made available on Partnership's website for further education and to support the provider network and discharge planning staff.
4. Partnership maintains mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services that apply to each of our Network Providers and Out-of-Network Provider hospitals within our Service Area.

G. TCS For Partnership Members with Other Health Insurance/ Multiple Payers
1. Partnership is responsible for providing TCS to Partnership assigned members even for services or benefits carved-out from Partnership's Medi-Cal contract. (e.g., hospitalization for a Medicare FFS dual-eligible member, in-patient acute psychiatric admissions, etc.)
2. For members who have multiple payers (other health insurance) and are undergoing any transition, Partnership will make a good faith attempt to obtain necessary ADT information from the corresponding facility. For these members, Partnership shall notify existing CCM and/or ECM care managers of the admission, discharge and/or transfer in the manner outlined above in section VI. C.

3. For members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential or crisis residential stay where the county Mental Health Plan is the primary payer, the county Mental Health Plan has the primary responsibility to coordinate the member's care upon discharge. Partnership and the county Mental Health Plan must share necessary data and information to coordinate care for TCS per APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023).
    a. Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
    b. Partnership shall identify a TCS care manager for these members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM or CS are addressed.
    c. TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
    d. After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.
4. For Partnership members who have Medicare as primary coverage for inpatient, acute, and/or skilled nursing services:
    a. The member's Medicare Medi-Cal Plan (MMP) or the member's Dual-Eligible Special Needs Program (D-SNP) is responsible for coordinating the delivery of all benefits covered by both Medicare and Partnership. Partnership shall not provide TCS or assign a transitional care manager for member enrolled in a Medicare Medi-Cal Plan or Dual-Eligible Special Needs Program (D-SNP).
        1) If the member is enrolled in ECM or Partnership's CCM Program, Partnership shall notify the care manager of the admission, discharge or transfer status.
    b. For Partnership members who are enrolled in Medicare FFS or Medicare Advantage plans that are not a D-SNP, Partnership shall ensure and provide TCS.
5. Drug Medi-Cal Organized Delivery System (DMC-ODS) or Partnership's Wellness and Recovery services:
    a. For members needing SUD services in counties participating in Partnership's Wellness & Recovery program (Regional Model), Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
    b. For members needing SUD services in the counties not participating in Partnership's Wellness & Recovery program, Partnership shall identify a TCS care manager for these members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM or Community Supports are addressed.
    c. TCS for this transfer/discharge end once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
    d. After the member's treatment at the behavioral health facility is complete and the member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

H. DHCS Monitoring of TCS
1. If Partnership contracts with or delegates to facilities or providers to provide full scope or specific components of TCS, Partership must have robust monitoring and enforcement process in place to hold facilities or providers accountable for providing all required TCS outlined above.

2. For more details on what DHCS will monitor with Partnerships' TCS implementation through specific PHM Monitoring Key Performance Indicators (KPIs), refer to the CalAIM Population Health Management Policy Guide for more details.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III – 4.3, Population Health Management and Coordination of Care
B. CalAIM Population Health Management Policy Guide January 2024
C. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)
D. DHCS APL 23-006 Delegation and Subcontractor Network Certification (03/28/2023)
E. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)
F. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023)
   1. Specialty Mental Health Services MOU template (DHCS contract Attachment E)
G. Title 42 Code of Federal Regulations (CFR) Section 438.208

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: N/A

PREVIOUSLY APPLIED TO:

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.