

DHCS Care Coordination Project:
Current Medi-Cal Contract and Legal Requirements for Transitions in Care

The transition requirements listed below are excerpts from the Code of Federal Regulations (CFR) Title 42 § 438.208 (b)(2) Final Managed Care Rule, California Department of Health Care Services (DHCS) Managed Care Plan (MCP), Mental Health Plan (MHP), Drug-Medi-Cal Organized Delivery System (DMC-ODS) boilerplate contracts, the DHCS Health Home Program (HHP) Program Guide, DHCS policy letters, and the California Knox-Keene Act (KKA).

CFR Title 42 § 438.208 (b)(2)

Medicaid Managed Care Final Rule:

"Each MCO, PIHP, and PAHP must coordinate the services it furnishes to the enrollee:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;
- With the services from any other MCO, PIHP, or PAHP;
- With the services the enrollee receives in FFS Medicaid; and
- With the services from community and social support providers."

DHCS MCP Boilerplate Contract

Discharge Planning and Care Coordination for Seniors and Persons with Disabilities (SPD) Beneficiaries:

"Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions."

"Contractor shall ensure the provision of discharge planning when a SPD beneficiary is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

- A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment Durable Medical Equipment (DME), and other services received.
- B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD

beneficiary as applicable, physical and mental function, financial resources, and social supports.

- C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.
- D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.”

“Submit policies and procedures for ensuring the provision of Discharge Planning.”

Skilled Nursing Facility Utilization:

“Contractor shall monitor skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitioning between the facilities and community.”

“Contractor shall provide to DHCS a quarterly report on support and retention of community placement. Contractor shall submit this report in a format specified by DHCS and shall include the following data elements:

- 3. The number of Members admitted in the prior quarter to a LTC facility and remained for less than 90 days, and who were afforded the choice of CBAS, MSSP, or IHSS after discharge. Contractor shall report these numbers to the extent that Contractor has been notified of Member admission and is covering part or all of the Member’s stay in a LTC facility;
- 4. The number of Members admitted in the prior quarter to, and remained in, an LTC facility for 90 days or more and who were afforded the choice of CBAS, MSSP, or IHSS after discharge;
- 5. The number of Members who transitioned to the community from an LTC facility, and which of those Members did not return to a facility during the subsequent 12 months 12-month period;”

Managed Long-Term Services and Supports (MLTSS):

“Contractor shall ensure that coordination of care services for Partial Dual Eligible Members and Medi-Cal Only Members reflect a person-centered, outcome-based approach and shall:

- 3. Span medical care and CBAS, MSSP, IHSS, and LTC with a focus on transitions;”

Community Based Adult Services:

“Contractor shall develop and implement an expedited assessment process to determine CBAS eligibility when informed of Members in a hospital or skilled nursing

facility whose discharge plan includes CBAS, or who are at high risk of admission to a skilled nursing facility.”

“Contractor shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.”

Complex Case Management Transitional Needs:

“Submit policies and procedures for assessment of transitional needs of members into and out of Complex Case Management services:

- 1) At the request of PCP or Member
- 2) Achievement of targeted outcomes
- 3) Change of healthcare setting
- 4) Loss or change in benefits
- 5) Member non-compliance”

Mental Health Plan Boilerplate Contract

The transition requirements listed below are excerpts from the California Department of Health Care Services Mental Health Plan boilerplate contract.

Coordination of Care (MHP Contract, Exhibit A, Attachment 10)

- A. The Contractor shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. (42 C.F.R. § 438.208(b).) These procedures shall meet Department requirements and shall do the following:
- 1) Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity. (42 C.F.R. § 438.208(b)(1).)
 - 2) Coordinate the services the Contractor furnishes to the beneficiary between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. Coordinate the services the Contractor furnishes to the beneficiary with the services the beneficiary receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its beneficiaries. (42 C.F.R. § 438.208(b)(2)(i)-(iv), Cal. Code Regs., tit. 9 § 1810.415.)
 - 3) The Contractor shall share with the Department or other managed care entities serving the beneficiary the results of any identification

and assessment of that beneficiary's needs to prevent duplication of those activities. (42 C.F.R. § 438.208(b)(4).)

- 4) Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards. (42 C.F.R. § 438.208(b)(5).)
- 5) Ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, subparts A and E, to the extent that such provisions are applicable. (42 C.F.R. § 438.208(b)(6).)

- B. The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries. The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. The MHP shall monitor the effectiveness of its MOU with Medi-Cal managed care plans. (Cal. Code Regs., tit. 9, § 1810.370.)
- C. The Contractor shall implement a transition of care policy that is consistent with federal requirements and complies with the Department's transition of care policy. (42 C.F.R. § 438.62(b)(1)-(2).)

Drug Medi-Cal Organized Delivery System (DMC-ODS) Boilerplate Contract

The transition requirements listed below are excerpts from the California Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System (DMC-ODS) boilerplate contract.

Beginning on page 31:

Coordination and Continuity of Care (42 CFR §438.208).

- A. The Contractor shall comply with the care and coordination requirements of this section.
- B. As all beneficiaries receiving DMC-ODS services shall have special health care needs, the Contractor shall implement mechanisms for identifying, assessing, and producing a treatment plan for all beneficiaries that have been assessed to need a course of treatment, and as specified below.
- C. The Contractor shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. These procedures shall meet Department requirements and shall do the following:
 3. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity.

4. Coordinate the services the Contractor furnishes to the beneficiary:
 - i. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
 - ii. With the services the beneficiary receives from any other managed care organization.
 - iii. With the services the beneficiary receives in FFS Medicaid.
 - iv. With the services the beneficiary receives from community and social support providers.
 5. Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.
 6. Share with the Department or other managed care organizations serving the beneficiary, the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
 7. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
 8. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.
- D. The Contractor shall implement mechanisms to comprehensively assess each Medicaid beneficiary identified by the Department as having special health care needs to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate providers.
- E. The Contractor shall produce a treatment or service plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:
3. Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.
 4. Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1).
 5. Approved by the Contractor in a timely manner, if this approval is required by the Contractor.
 6. In accordance with any applicable Department quality assurance and utilization review standards.
 7. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).
- F. For beneficiaries with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow beneficiaries to directly access a specialist as appropriate for the beneficiary's condition and identified needs.

Example of language from the county-specific language:

D. Coordination of Care

In addition to the general coordination and continuity of care requirements outlined in Article III.G of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor coordination and continuity of care requirements:

1. Reassessments:

- i. The Contractor shall reassess all outpatient and intensive outpatient treatment beneficiaries, at a minimum of every 90 days, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.
- ii. The Contractor shall reassess beneficiaries initially authorized for residential treatment, at a minimum of every 30 days, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.

2. Transitions to Other Levels of Care:

- i. The Contractor's Case Managers shall ensure the transition of the beneficiaries to appropriate LOC. This may include step-up or step-down in SUD treatment services. Case Managers shall provide warm hand-offs and transportation to the new LOC when medically necessary and documented in the individualized treatment plan.
- ii. The Contractor's Case Managers shall ensure transitions to other LOCs will occur within ten business days from the time of assessment or reassessment with no interruption of current treatment services.
- iii. The Contractor shall manage a beneficiary's transition of care to a DMC-ODS provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility.
- iv. The Contractor shall manage a beneficiary's transition of care to a DMC-ODS provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in a subcontracted Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital.

DHCS Health Home Program (HHP) Guide (APL 16-003)

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-012.pdf>

Comprehensive Transitional Care:

“Comprehensive transitional care includes services to facilitate HHP members’ transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP member admissions and readmissions. Agreements and processes to ensure prompt notification to the member’s care coordinator and tracking of member’s admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, MCPs or CB-CMEs must provide information to hospital discharge planners about HHP.

Comprehensive transitional care services include, but are not limited to:

- Providing medication information and reconciliation
- Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners
- Collaborating, communicating, and coordinating with all involved parties
- Easing the member’s transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services
- Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures
- Developing and facilitating the member’s transition plan
- Preventing and tracking avoidable admissions and readmissions
- Evaluating the need to revise the member’s Health Action Plan (HAP)
- Providing transition support to permanent housing”

Health Information Technology/Data:

“MCPs should consider the following potential uses of HIT/HIE (as recommended by CMS) in the development of HHP information sharing policies and procedures for MCPs, CB-CMEs, and members:

- Comprehensive Transitional Care:
 - Automated care transition notifications/alerts, e.g. when a patient is discharged from the hospital or receives care in an ER.
 - Ability to electronically share care summaries/referral notes at the time of transition and incorporate care summaries into the EHR.
 - Referrals tracking to ensure referral loops are closed, as well as e-referrals and e-consults.”

Required HHP Training Topics:

“All MCP and Community Based Care management Entity (CB-CME) staff participating in the administration of the HHP are required to receive training on best practices for working with members and providers to design and implement the Health Action Plan,

conduct care coordination activities, and support patient transitions between different levels of care.

Required training shall cover approaches and best practices for developing and implementing a Health Action Plan and providing patient-centered care, taking into account the individual's preferences, values, and unique needs. It shall also cover best practices for care management for specific chronic diseases that are prevalent in the patient population and best practices for serving the SMI population.

Staff shall be trained in best practices for coordinating care across care settings, with particular focus on medical care, behavioral health services, and services addressing social determinants of health and housing. Training shall include effective strategies for care transitions, including best practices for reducing hospital readmissions and medication errors at care transitions.”

Readiness Requirements and Checklist:

“Submit MCP’s policies and procedures for conducting care transitions, including discharge-planning workflows.”

DHCS APL 17-017

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-017.pdf>

Long Term Care Coordination and Disenrollment

“All MCPs are required to provide coordination of care to beneficiaries who meet medical necessity criteria for LTC, including coordinating placement in an LTC facility that provides the level of care most appropriate to the beneficiary’s medical needs for LTC. Coordinating placement in an LTC facility includes coordinating the transfer of the beneficiary to the LTC facility; notifying the beneficiary and his or her family or guardian of the transfer to the LTC facility; assuring the appropriate transfer of medical records to the LTC facility; assuring that continuity of care is not interrupted; and continued provision of all medical necessary covered services to the beneficiary while the beneficiary is enrolled in the MCP. The responsibility to coordinate the placement of a beneficiary in an LTC facility is not contingent on the beneficiary’s expected length of stay at the LTC facility.”

DHCS DPL 16-003

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2016/DPL16-003.pdf>

Discharge Planning for Cal MediConnect:

“A Cal MediConnect member must have all necessary supports and services arranged upon discharge from a hospital or institution, such as a Skilled Nursing Facility (SNF), to living in the community. Medicare-Medicaid Plans (MMPs) are responsible for ensuring the provision of a member’s medical needs, supports, and services are completed

throughout the post-discharge and transition to community-based care period. In accordance with the contract, the minimum criteria for discharge planning include:

- Documentation of pre-admission or baseline status;
- Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community-based LTSS programs;
- Initial coordination of care, as appropriate with the member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the member's care coordinator contact information is readily available for hospitals; and
- Provision of information for making follow-up appointments.

MMPs are responsible for ensuring that all medically necessary services are provided in a timely manner upon discharge, and that a member's transition to the most appropriate level of care and community-based care occurs, from the hospital or institution, that meets the member's medical and social needs. MMPs must ensure that members have access to the full spectrum of Medicare and Medi-Cal covered benefits across all levels of care, including inpatient rehabilitation facilities, long-term care hospitals, the partial hospitalization program, nursing facilities, and the full range of home and community-based services and supports."

California Knox-Keene Act

KKA CCR Title 28 § 1300.67 (b):

"The basic health care services required to be provided by a health care service plan [within the Knox-Keene section of law] to its enrollees shall include, where medically necessary, subject to any copayment, deductible, or limitation of which the Director [of DHCS] may approve:

(b) Inpatient hospital services, which shall mean short-term general hospital services, including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early rehospitalization."