State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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CCT PL #16-010

Date: May 31, 2016

To: CCT Program Director

Subject: Community Physician Requirement

POLICY EFFECTIVE ON: June 1, 2016

PURPOSE

This California Community Transitions (CCT) Policy Letter (PL) establishes a new policy affecting post-transition community-based, primary care physician (PCP) requirements. As of the effective date of this PL, Lead Organizations (LOs) are required to:

1. Identify a community physician willing and able to accept the CCT Enrollee under his/her practice;

2. *(within Coordinated Care Initiative [CCI] and County-Operated Health System [COHS] counties only)* Identify the managed care plan in which the CCT Enrollee is currently a member, and work closely with the managed care plan to locate the current or newly-assigned PCP;

3. (*within non-CCI, non-COHS counties*) Identify the managed care plan into which the CCT Enrollee will enroll upon being discharged from an inpatient facility; and:

   A. Assist the CCT Enrollee in completing and submitting care plan enrollment paperwork; and, while managed care enrollment is being processed,

B. Work with the CCT Enrollee to identify a community PCP who is a member of the managed care plan's provider network, and is able and willing to accept new Medi-Cal patients;

4. Schedule an intake appointment with the community PCP no later than the first week after transition (preferably, as soon after the day of transition as possible); and

5. Include the date of the scheduled community PCP intake appointment in the CCT Final Transition and Care Plan (FTCP) ***PRIOR*** to transitioning the individual to the community.

BACKGROUND

The Deficit Reduction Act (DRA) of 2005 establishes four primary objectives for Money Follows the Person (MFP) (MFP is known as CCT in California) Demonstration Grantees. The first two objectives address rebalancing, with respect to institutional and home and community-based long-term care services under State Medicaid programs, and the flexible use of Medicaid funding to allow eligible members to receive care in the settings of their choice. This policy letter addresses objectives three and four, which require:

> (3) CONTINUITY OF SERVICE.—Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.
>
> (4) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.[1]

The requirements established through this PL were created to improve the continuity of medical services across settings, and to help ensure CCT Enrollees do not move into the community without adequate primary care coverage included in their *Transition and Care Plans*. This PL was informed by a white paper[2] cited by the Centers for Medicare and Medicaid Services (CMS) as a resource to guide MFP grantees seeking to improve

[1] Deficit Reduction Act of 2005, Chapter 6 - Other Provisions, Subchapter B - Money Follows the Person Rebalancing Demonstration. Public Law 109–171. February 8, 2006.

[2] American Medical Directors Association (AMDA). Improving Care Transitions from the Nursing Facility to a Community-Based Setting. *(White Paper C09, Becomes Policy March 2009)*. www.amda.com

the quality and continuity of services and supports provided to CCT Enrollees and Participants transitioning from an institution to the community. The paper was issued by the Society for Post-Acute and Long-Term Care Medicine, American Medical Directors Association (AMDA), and emphasizes the critical importance of the community PCP's role in the success of an institution-to-community transition. The authors of the paper explain:

> Issues related to transitioning patients across sites of care increasingly have been in the national spotlight. There is evidence that poor transitions may result in adverse outcomes such as an avoidable re-hospitalization or medication errors. Problematic transitions often involve inadequate participation by a primary care provider (PCP).[3]

In July of 2014, DHCS included a space at the end of the CCT FTCP for community PCPs to sign to indicate (s)he would provide primary care to the individual in the community. However, DHCS recognized that follow-up policy guidance was required when FTCPs signed by inpatient facilities' medical directors were submitted to DHCS' Nurse Evaluators (NEs) for adjudication. The intent of having the community physician sign the FTCP was to show that the CCT Enrollee would not experience a break or disruption in primary care services upon discharging to the community from the institution. Because the facility's responsibility for the resident ends when the individual discharges, the only instance in which a facility medical director's signature would be appropriate on the FTCP would be if (s)he has a private practice in the community and accepts the member into his/her community-based practice upon discharge.

DHCS encourages the involvement of facility medical directors in the transition and care planning process, if and when a CCT Enrollee wishes to have him/her on the transition and care planning team; however, the facility's medical director is not required to "sign off" on the CCT care plans.

POLICY

Effective June 1, 2016, CCT LOs will no longer be required to have a community physician sign the FTCP.

Instead, CCT LOs will be required to include the date of the scheduled PCP intake appointment in all FTCPs. 50-hour follow-up Treatment Authorization Requests (TARs) will not be approved until an appointment is scheduled and has been documented in the FTCP. FTCPs must be submitted as close to the transition date as possible but will no longer be required to be submitted 2 weeks prior to transition.

[3] Farrel JD, Dabogal F, Lett JE. Nursing Homes: The Critical Link to Safe Transitions Home. CAHQ Journal. Quarter 2, 2008.

PROCESS

Medi-Cal members have access to a variety of care management systems that affect the ways in which CCT LOs will work to establish primary care for the CCT Enrollee. Please see Attachment 1 for more information on the responsibilities of Managed Care Plans across the state.

- If the CCT Enrollee plans to move into a non-CCI county after discharge, Transition Coordinators (TCs) may work directly with PCPs to schedule an intake appointment on behalf of the individual. It is recommended that TCs work to enroll the CCT Enrollee in a managed care plan for continued continuity of care, but enrollment into Medi-Cal managed care is voluntary for dual eligible members, individuals enrolled in full-scope Medicare and Medi-Cal, in non-CCI counties.

- If the CCT Enrollee plans to move into a CCI or COHS County, the TCs will be required to coordinate efforts with the individual's managed care plan.

Differences between CCI/COHS and non-CCI Counties:

	CCI and COHS Counties	Non-CCI Counties
When to contact the Managed Care Plan to begin the Collaborative Enrollment Process	Immediately after determining the individual is eligible to transition.	**At least** a month in advance of transition, more time may be required in areas with fewer PCPs accepting Medi-Cal beneficiaries. If enrolling in Managed Care, begin two to three months in advance of the transition to ensure the member is enrolled in the managed care plan after transition (30-90 days of processing is generally required for enrollment, depending on the county). It is recommended to identify a community PCP who will accept fee-for-service reimbursement and is a provider in the managed care plan's provider network, to ensure the CCT Enrollee will have access to a community PCP while managed care enrollment is being processed.
Who to Contact to Secure a Community Physician	Managed Care Plan	Medi-Cal Primary Care Physician
When is a PCP Intake Appointment Confirmation Due	2 weeks prior to transition (attached to the FTCP).	2 weeks prior to transition (attached to the FTCP).

What to Submit to the DHCS NE	FTCP with the date of the scheduled community PCP intake appointment no later than the first week after transitioning to the community.	FTCP with the date of the scheduled community PCP intake appointment no later than the first week after transitioning to the community.
Safeguard in Extreme Circumstances	If the Managed Care Plan is not willing/able to schedule an intake appointment prior to discharge from the facility, the CCT LO has up to 14 calendar days after the day of transition to schedule the intake appointment and submit the date of the appointment to the assigned state NE (the 50-hour follow up TAR will not be approved without a scheduled community PCP intake appointment).	If the community PCP is not willing/able to schedule an intake appointment prior to discharge from the facility, the CCT LO has up to 14 calendar days after the day of transition to schedule the intake appointment and submit the date of the appointment to the assigned state NE (the 50-hour follow up TAR will not be approved without a scheduled community PCP intake appointment).

COMPLIANCE

The importance of ensuring the MFP continuity of care grant requirement for CCT Participants transitioning from inpatient care facilities to the community cannot be overemphasized. To ensure individuals participating in CCT are able to live in the community setting of their choice, CCT LOs must ensure they have access to reliable and medically-appropriate care, equivalent to the care they received in the inpatient facility.

QUESTIONS

For further questions about this PL, please contact Karli Holkko at (916) 322-5253, or by e-mail at: karli.holkko@dhcs.ca.gov.

Sincerely,

(Originally signed by)

Rebecca Schupp, Chief
Long-Term Care Division

Attachments (1)