

<b>POLICY AND PROCEDURE</b>	
<b>Title:</b> Transitional Care Services	
<b>Primary Policy owner:</b> Utilization Management	<b>Policy #:</b> UM88
<b>Impacted/Secondary policy owner:</b> Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) <input type="checkbox"/> All Departments 2) <input checked="" type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input type="checkbox"/> Benefits Administration (BA) 4) <input checked="" type="checkbox"/> Case Management (CM) 5) <input type="checkbox"/> Claims (CLMS) 6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input type="checkbox"/> Configuration (CFG) 9) <input checked="" type="checkbox"/> Provider Contracting (CONT) 10) <input type="checkbox"/> Cultural & Linguistics (CL) 11) <input type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input type="checkbox"/> Information Technology / Core Systems (IT) 16) <input type="checkbox"/> Pharmacy (PH) 17) <input checked="" type="checkbox"/> Provider Networks (PRO) 18) <input checked="" type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input checked="" type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input checked="" type="checkbox"/> Medical Management (MM)
<b>Product Type:</b> <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> D-SNP	<b>Supersedes Policy Number:</b> N/A

**I. PURPOSE**

To ensure seamless member transitions from one setting or level of care (LOC) to another, which includes 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.

## II. **POLICY**

- A. Health Plan of San Joaquin and Mountain Valley Health Plan (“Health Plan”) provides strengthened Transitional Care Services (TCS) as defined in the current version of Department of Health Care Services CalAIM: Population Health Management (PHM) Policy Guide.
- B. Health Plan members are supported by transitional care services until they have been successfully connected to all related services and supports.
- C. Health Plan ensures that all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and durable medical equipment (DME) needing Prior Authorization.
- D. Ensure that mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services exist between Contractor and each of its Network Provider and Out-of-Network Provider hospitals within its Service Area.
- E. Prior authorizations are completed within timeframes consistent with the urgency of the Member’s care in accordance with Health Plan Policy UM 01: Authorization and Referral Review including:
  1. Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Health Plan is responsible, and DME that are processed in accordance with 42 CFR section 438.210, H&S Code section 1367.01, and Exhibit A, Attachment III, Section 2.3 (Utilization Management Program) of Health Plan’s contract with DHCS.
- F. Members transitioning to a Nursing facility are transitioned in accordance with Health Plan Policy UM 82: Long Term Care.
- G. Health Plan ensures the following for high-risk transitioning members:
  1. High risk members are defined by the following criteria:
    - a. Through Health Plan’s risk stratification (RSS),
    - b. Through PHM (Population Health Management) Service once statewide RSS and risk tiers are available.

- c. Other members including but not limited to:
    - i. Those with LTSS (Long Term Services and Supports) needs.
    - ii. Those in or entering ECM (Enhanced Care Management) or CCM (Complex Case Management).
  - d. Children with special health care needs (CSHCN).
  - e. All Pregnant individuals: for the purposes of TCS, "pregnant individuals" includes any individual hospitalized during pregnancy or admitted during the 12-month period postpartum, including discharges related to the delivery.
  - f. Seniors and persons with disabilities who meet the definitions of "high-risk" established in the current PHM Policy Guide.
  - g. Any member who has been served by county Specialty Mental Health Services (SMHS) and/or Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) (if known) within the last 12 months, or any member who has been identified as having specialty mental health needs or substance use disorder by Health Plan or discharging facility.
  - h. Any member transitioning to or from a Skilled Nursing Facility (SNF).
  - i. Any member that is identified as high risk by the discharging facility and thus is referred to or recommended by the facility for high-risk TCS.
2. Health Plan assigns a single point of contact (SPOC)/Care Manager (CM) to fulfill TCS requirements upon identification of a high-risk member being admitted.
  3. The SPOC/CM is responsible for ensuring completion of all transitional care coordination services in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up after discharge.
    - a. This includes assessing the member's risk for adverse outcomes to inform needed TCS.
      - i. This must include reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary).

- ii. The care manager may supplement this risk assessment as needed through member engagement.
    - b. After discharge, upon member engagement, care manager must review the discharge instructions with the member and ensure that member can have any questions answered.
    - c. Ensuring needed post-discharge services are provided and follow-ups are completed, including (but not limited to) by assisting with making follow-up provider appointments, to occur within 7 days post-discharge; connecting to the PCP (if different); and arranging transportation
    - d. The Care Manager must ensure medication reconciliation is complete after individual is discharged. This can be done by the follow-up provider, such as the PCP, or by the care manager if they hold an appropriate license, or by another team member on the care manager's team that has appropriate license, in a manner that is consistent with California's licensing and scope of practice requirements, as well as applicable federal and state regulations
    - e. Substance Use Disorder (SUD) and mental health treatment initiation or continuation for those who have an identified SUD or mental health condition.
    - f. Completion of referrals to social service organizations (county First 5s, etc.), and referrals to necessary at-home services (DME, home health, etc.).
    - g. Connection to community supports as needed, and
    - h. For members who are transferred to/from nursing facilities, ensure completion of care coordination tasks in the contract including:
      - i. Ensure outpatient appointments are scheduled prior to discharge.
      - ii. Verify that Members arrive safely and have their medical needs met.
    - i. Follow-up with Members to ensure all TCS needs and requirements have been met
4. For Health Plan members enrolled in ECM or CCM, notification to

- the assigned ECM or CM are completed within 24 hours of Health Plan notification of a member's admission, discharge, or transfer, or identification of a planned admission.
- a. All TCS requirements are completed by the ECM or CCM Care Manager once notified by Health Plan.
  - b. Health Plan communicates with the assigned ECM, as well as facility, to ensure participation in discharge planning and support access to available services.
5. The assigned ECM/Care Manager ensures that needed post discharge services are provided, and follow-ups are scheduled, including any necessary referrals.
  6. Health Plan members must be offered the direct assistance of the CM, but may choose to have limited or no contact with the CM.
    - a. In this instance, the CM must act as a liaison coordinating care among the discharging facility, Primary Care Provider (PCP) and Health Plan.
  7. TCS extends until the member has been connected to all needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document.
    - a. TCS for high-risk members should always extend at least 30 days post-discharge.
    - b. Appropriate referrals are made for ECM and CCM when identified during provision of TCS.
- H. Health Plan, or the ECM/CCM provider obtains permission from Members, 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.
- I. Health Plan ensures the following for low risk transitioning members:
1. A dedicated team and phone number to support transitioning members telephonically when they request help which meets the following requirements:
    - a. During business hours, Health Plan ensures that members are able to connect with a live team dedicated to TCS. If using an automated phone tree under "member services" or

- similar, transitioning members must not have to select more than one option before reaching this dedicated line.
- b. Outside of business hours, the plan must ensure that:
    - i. Members are referred to emergency services if needed.
    - ii. Members can leave a message.
    - iii. Messages are shared with the dedicated TCS team. A TCS team staff must respond to members within one business day after the initial phone call.
  - 2. The member has access to a specialized TCS team (at Health Plan or a delegate) for a period of at least 30 days from the discharge;
  - 3. Ambulatory follow-up occurs within 30 days of discharge
  - J. Health Plan is responsible for knowing, in a timely manner, when all members have planned admissions, and when they are admitted, discharged, or transferred, and experiencing a transition, through the following mechanisms:
    - 1. ADT (admission, discharge, transfer) feeds, when available
    - 2. Established data-sharing agreements with facilities from which Health Plan does not receive ADT data, and
    - 3. Existing prior authorization requests.
  - K. Health Plan ensures Closed Loop Referrals to Community Supports and coordination with county social service agencies and waiver agencies for in home support services (IHSS) and other home and community-based services (HCBS) on July 1, 2025.
  - L. Health Plan prevents delayed discharges of a member from a hospital, institution, or facility due to circumstances such as, but not limited to, authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur.
  - M. When a Health Plan Member has multiple payors and experiences a transition:
    - 1. Health Plan identifies these members through ADT reporting and notify the appropriate CM, ECM or CCM of the members' needs for these services.
    - 2. If a Health Plan member is dual eligible for Medicare and Medi-Cal and enrolled in Medicare FFS or Medicare Advantage (MA)

- Plan, Health Plan is responsible for ensuring all transitional care requirements are met.
3. For Health Plan members who are admitted to an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, where the County Mental Health Plan (MHP) is the primary payor, or admitted for residential substance use disorder (SUD) treatment, including residential withdrawal management, where the Drug Medi-Cal Organized Delivery System (DMC-ODS) is the primary payor, Health Plan or the DMC-ODS are primarily responsible for coordinating care with the member upon discharge.
    - a. Health Plan has assigned a CM to coordinate with behavioral health or county health care coordinators, ensure the member's physical health needs are met, and assess for additional CM needs or services such as ECM, CCM or Community Supports (CS).
    - b. Health Plan maintains memoranda of understanding (MOU) with required entities, including County MHPs, to facilitate care coordination and ensure non-duplication of services.
      - i. MOUs are established with additional entities, including local alcohol and SUD treatment services.
    - c. For Health Plan members who are initially admitted for a medical condition and then transferred or discharged to a mental health facility, including a SUD psychiatric or residential rehab facility:
      - i. Health Plan is responsible for TCS during the transfer/discharge to the behavioral health facility.
  4. The assigned care manager ensures Members with SUD and mental health needs receive treatment for those conditions upon discharge.
- N. TCS ends once the member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
1. Medication reconciliation and information sharing between institutions should be complete prior to the member's transfer.

- O. Health Plan monitors the following Key Performance Indicators (KPI's) to assess the efficacy of TCS services:
1. ER visits/1,000 members,
  2. PCP visits within seven (7) and 30 days post discharge, and
  3. Readmissions within 30 days.

### III. PROCEDURE

- A. When Health Plan is notified of a member's change in level of care:
1. A SPOC or CM is assigned to assist the member during their transition to the lower level of care.
    - a. For members enrolled in ECM or CCM, the provider of these services is notified of the members admission, discharge, or transfer, including location, within 24 hours of identification.
    - b. The contact information for the ECM or CM, including phone number, is included in the discharge planning document.
  2. The SPOC/ECM/CM initiates contact with the member while in the facility, and:
    - a. Identifies discharge needs.
    - b. Participates in the members' discharge planning by collaborating with the facility discharge planner and Health Plan's CCRN (Concurrent Review Registered Nurse).
    - c. Ensures each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances.
    - d. Members must not be discharged to a setting that does not meet their medical and/or long-term services and supports (LTSS) needs.
    - e. Ensures collaboration, communication, and coordination with the member and their family/support person(s)/guardian, the hospital or ED, LTSS providers, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate a safe and successful transition.
    - f. Ensures completion of medication reconciliation prior to and after discharge,

- g. Coordinates and verifies that the member receives all appropriate TCS, regardless of setting.
      - h. Identifies referrals the member may need during the transition period such as CCM, ECM, Community Supports, In Home Support Services (IHSS) and Home and Community Based (HCBS) waiver programs.
3. The CM/ECM/CCM ensures all transitional care management activities occur as described in this Policy, though another team member may perform some of the activities.
4. The CM/ECM/CCM ensures follow-ups are scheduled, including:
  - a. Provider appointments,
  - b. SUD and mental health treatment initiation, as needed,
  - c. Medication reconciliation,
  - d. Referrals to social service agencies, as needed, and
  - e. Referrals for necessary at-home services.
5. Health Plan assigned CM/ECM/CCM ensures members with SUD and mental health needs receive treatment for those conditions upon discharge.

#### **IV. ATTACHMENT(S)**

- A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
- B. [Glossary of Terms Link](#)
- C. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

#### **V. REFERENCES**

- A. California Health & Safety Code (H&S) Code section 1367.01
- B. Code of Federal Regulations 42 CFR section 438.210
- C. Department of HealthCare Services All Plan Letter (APL): 22-024: Population Health Policy Guide.
- D. Department of HealthCare Services 2024 contract Exhibit A, Attachment III, Section 4.3.11 Transitional Care Services
- E. Department of HealthCare Services CalAIM: Population Health Management (PHM) Policy Guide

- F. Exhibit A, Attachment III, Section 2.3 (Utilization Management Program) of Health Plan's contract with DHCS.
- G. Health Plan Policy PHM01 Population Health Management
- H. Health Plan Policy UM 01 Authorization and Referral Review
- I. Health Plan Policy UM 82 Long Term Care

## VI. REVISION HISTORY

Version*	Revision Summary	Date
000	New policy created to comply with PHM TCS requirements	6/9/2023
001	Fixed Formatting	8/11/2023
002	Updated/Added: Covered settings, High-risk criteria, TCS components descriptions, High vs. low-risk requirements, End of TCS; Removed: Requirement for DHCS approved risk screening, Requirement for DC planning document sent by TOC Care Manager	8/30/24
003	Revision to better organize/align high vs. low risk expectations and remove redundancies	11/20/24
004	Update to reflect current PHM requirements and address comments	10/07/2025
<b>Initial Effective Date:</b> 01/01/2023		
<b>Published Date:</b> 02/05/2026		

## VII. Committee Review and Approval to be Completed by Compliance

Committee Name	Version	Date
Compliance Committee (CC)	004	02/03/2026
<ul style="list-style-type: none"> <li>• Privacy &amp; Security Oversight Committee (PSOC)</li> </ul>		
<ul style="list-style-type: none"> <li>• Program Integrity Committee (PIC)</li> </ul>		
<ul style="list-style-type: none"> <li>• Audits &amp; Oversight Committee (AOC)</li> </ul>		
<ul style="list-style-type: none"> <li>• Policy Review Committee (PRC)</li> </ul>	002	09/20/2023

Quality Improvement Health Equity Committee (QIHEC)		
<ul style="list-style-type: none"> <li>Quality Operations Committee (QOC)</li> </ul>		
<ul style="list-style-type: none"> <li>Grievance Committee (GC)</li> </ul>		

### VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	MCOD Operational Readiness	002	09/29/2023
Department of Managed Care (DMHC)			

### IX. Approval signature\*

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

\*Signatures are on file, will not be on the published copy