McLAREN HEALTH PLAN **POLICY & PROCEDURE MANUAL**	**Initial Approval Date:** 11/19/19 **Effective Date:** 11/19/19 **Effective Revision Date**: 03/16/21 **Last Review Date:** 01/16/24
SCOPE McLaren Health Plan	**Review Cycle:** Annually
SUBJECT Transitions of Care	**POLICY NUMBER** 11-35
SECTION Utilization Management	**AUTHORIZED BY** Quality, Safety and Service Improvement Committee

POLICY STATEMENT

It is the policy of McLaren Health Plan (MHP) to provide continued services to Medicaid enrollees whose health would be jeopardized if health care services were disrupted or ceased during transition from another Medicaid Managed Care plan or Medicaid Fee for Service (FFS) plan.

PURPOSE

To maintain the health and wellness of MHP's vulnerable population by defining a consistent process for Medicaid members who transition from one Medicaid Managed plan to another or to/from Medicaid Fee for Service (FFS). To comply with transition of care requirements for Medicaid Managed Care as defined under 42 CFR, Section (§) § 438.62 and § 457.1216.

PROCEDURE

Public Availability

This Transition of Care Policy will be available on MHP's website for public access. In addition, instructions to members on how to access continued services upon transition will be included in the member handbook.

Applicability of the Policy

This policy is applicable to Medicaid members that may suffer serious detriment to his/her health and/or hospitalization or institutionalization in the absence of continued access to services during transition. Situations may include but are not limited to:

- Have significant health care needs or complex medical conditions;
- Are receiving ongoing services such as dialysis, home health care, chemotherapy, and/or radiation therapy;

- Currently in active treatment due to an injury or illness, including chronic conditions such as asthma, cancer, diabetes, HIV/AIDS, heart disease, emphysema, COPD, hypertension, and sickle cell anemia;
- Currently pregnant or receiving routine care indicative of a pregnancy up to 60 days post-partum or for the care of a newborn;
- Currently in active treatment for a behavioral health or substance use disorder;
- Surgical procedure within the past 90 days;
- Receiving targeted case management services;
- Receiving hospice services;
- Receiving adult foster care services;
- Current foster child;
- CSHCS enrollees (all);
- Individuals dependent on a ventilator

Out of Network (OON) Providers Covered
Providers covered by this policy include:

- Primary Care Provider (PCP)
- Specialists
- Hospitals
- Clinics
- Dentists
- DME and ancillary service providers in certain circumstances

Prior Relationship with Provider
Continuity of care requires that a relationship with a provider has already been established. MHP will review utilization data to determine which providers have an established relationship with the member. A relationship exists when:

> **Specialists:** The enrollee must have seen the specialist at least *once* within the six months prior to MHP enrollment for a nonemergency visit.
> **Primary Care Provider:** The enrollee must have seen the primary care provider at least *once* within the six months prior to MHP enrollment for a non-emergency visit.
> **Other Covered Providers**: The enrollee may have received services from other providers within the past six months prior to MHP enrollment. MHP will review, assess and coordinate those services, if it is determined that the enrollee will suffer serious detriment or be at risk for hospitalization or institutionalization.

If MHP cannot determine if a relationship exists based on the available data, MHP will ask the provider and enrollee to provide documentation of the visit from the medical record or proof of payment to establish the relationship.

Requesting Continuity of Care Coverage

MHP will ask the member about upcoming appointments during new member onboarding calls to evaluate for possible OON providers. MHP will work to establish agreements with OON providers where necessary. MHP will evaluate claims data to establish continuity of care. If data is not available to establish a relationship with the member's provider, the member or his/her appointed representative may request continuity of care. The member's OON provider may also request continuity of care on behalf of the member. Requests for continuity of care should be made by contacting MHP's Customer Service or by submitting a request to Medical Management. Requests may be made verbally or in writing. When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with MHP.

Request Processing
MHP must make a good faith effort to assess the transitioned member's history and current medical, dental, behavioral health, and social needs and concerns as soon as possible (generally in 5 business days to a maximum of 30 business days of transition). This is completed during new member onboarding. If there is a risk of harm to the member, or rescheduling of the appointment would be required, MHP will assign a case manager for ongoing monitoring of progress and care plan updates. Urgent requests must be completed within three business days.

For the purpose of Transition of Care, medical necessity is met if the service:

- Meets generally accepted standards of medical practice;
- Is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
- Is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
- Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
- Is not provided primarily for the economic benefit or convenience of anyone other than the recipient.
- Effective October 1, 2020 the enrolling Contractor must honor the disenrolling Contractor's prior authorization if any, for a period of 90 days from enrollment into the new Contractor and the prior authorization document should be submitted by the beneficiary or the provider.

A Medical Management issue will be created by Outreach for members that require an authorization for transition of care services/supplies and for case management needs.

Once a member is determined eligible for transition of care, MHP will request approved prior authorizations from the previous health plan.

Prior authorizations must be transferred to the new health plan from the previous health plan, and the new health plan must honor the prior authorizations.

The transitioned member is eligible for continued, clinically equivalent services by an equivalent provider if, during the previous 6 months, the transitioned member was treated by that provider for a condition that requires follow-up care or additional treatment, or the services have been prior authorized by the previous plan.

If the transitioned member's specialty provider is no longer available to the member through the MHP network, MHP must ensure access to services consistent with the access the transitioned member previously had and will retain their current provider from a previous plan for a period of at least 90 days to ensure continued services and assist the transitioned member in selecting a network provider. Services may be extended based on member needs.

Coverage Period
PCPs, Specialists, and other covered providers: MHP will maintain current providers and level of service at the time of enrollment for at least 90 days. This includes existing prior authorizations for 90 days for scheduled surgeries, dialysis, chemotherapy, radiation, and transplants (organ, bone, hematopoietic stem cell).

Durable Medical Equipment (DME) and custom-fabricated equipment: MHP will honor existing prior authorizations *for items that have not been ordered* for 90 days and will review ongoing prior authorizations for medical necessity. This policy does *not* include mass-produced readily available items that can be used by a person other than for whom it was ordered, all rental items, all expendables/disposable medical supply items (e.g. Diapers, dressing, ostomy supplies, IV infusion supplies) or any other item that does not require a length of time (days or weeks) to special order for a specific person as long as the new benefit plan to which the member transitions into provides continuity of care for those services for a minimum period of 30 days or has a physician evaluate and review the ongoing medical necessity, whichever is sooner. MHP is responsible to provide an alternate equivalent service when available and for finding an INN provider to deliver those services without disruption or cover the OON service for a period of 30 days when an alternate equivalent service is not available after notifying the member.

The Managed Health Plan that authorizes and orders the equipment or item is responsible for paying for the item even though it is delivered after the member loses eligibility or has an enrollment change. The order must be placed before the change in enrollment status, and the service should be delivered, within 90 days after the change in enrollment status.

Transportation: Includes ambulance transportation. MHP will honor prior authorizations and/or physician's orders for the time period covered until reviewed by the physician.

Prescriptions: MHP will cover maintenance drugs for at least 90 days without prior authorization when:

- The member is taking a drug that is not covered by MHP, or
- MHP's rules do not cover the amount ordered by the prescriber, or

- The drug requires prior authorization by MHP, or
- The member is taking a drug that is part of a step therapy restriction.

  A maintenance drug is defined as a drug where the member has received a 30-day supply of the drug in the previous 90 days. MHP will send at least one notice to the enrollee and at least one notice to the enrollee's prescriber informing them of the enrollee's options to obtain a prior authorization to continue on the drug therapy or to switch to a therapeutic alternative drug that does not require prior authorization. MHP must cover the drug for at least 90 days following the date of enrollment.

Prescriptions

MHP will cover a maintenance drug for at least 90 days without prior authorization if:

- The enrollee is taking a drug that is not covered by MHP, or
- The MHPs rules do not cover the amount ordered by the prescriber, or
- The drug requires prior authorization by MHP, or
- The enrollee is taking a drug that is part of a step therapy restriction.

For the purposes of this policy, a maintenance drug is defined as a drug where the member has received a 30-day supply of the drug in the previous 90 days. MHP must send at least one notice to the enrollee and at least one notice to the enrollee's prescriber informing them of the enrollee's options to obtain a prior authorization to continue on the drug therapy or to switch to a therapeutic alternative drug that does not require prior authorization. MHP must cover the drug for at least 90 days following the date of enrollment.

Interdisciplinary Transition of Care Team (ITC)

MHP has an ITC team that is responsible for implementation and oversight of the Transition of Care Policy and the management of all processes. The team includes licensed clinical nurses and other staff necessary to provide support for transition services. The Director of Medical Management, a licensed Registered Nurse is responsible for ITC oversight.

ITC Members include:

- Chief Medical Officer
- Director Medical Management
- Manager Medical Management
- Case Management Nurses
- Pharmacy staff
- Other members as necessary including member providers

Communication Plan

The Director of Medical Management is responsible for communication of the Transitions of Care Policy and communication. Communication includes:

- Transition of Care Policy will be posted for member and public viewing on the MHP website.

- Transition of care information will be included in new member welcome packets and in the member handbook.
- Transition of Care Policy will be reviewed and revised at least annually
- Transition of Care Policy will be reviewed with MHP staff that interact with members and providers upon implementation and on an annual basis. MHP staff include Customer Service, Network Development, Outreach, and Medical Management.
- Network Development Director is responsible for ensuring distribution to members via the member handbook and other methods as appropriate.

Children's Special Health Care Services (CSHCS) Members
CSHCS requirements will supersede any Transition of Care Policy requirements.

MHP will allow CSHCS members to remain with his/her established PCP at the time of enrollment not limited to Network Providers; upon consultation with the family and care team, CSHCS Enrollees may be transitioned to an INN PCP when appropriate.

MHP will allow a CSHCS member to choose a non-network PCP if:

a. The CSHCS member has an established relationship with the PCP at the time of enrollment with MHP.
b. Upon consultation with the family, the selected PCP is the most appropriate for the CSHCS member.

MHP will assess the need for a care manager and a family centered care plan developed in conjunction with the family and care team.

MHP will maintain separate specific prior authorization procedures for CSHCS members (see CSHCS SOP).

MHP will accept prior authorizations in place for ancillary services (therapies, medical supplies) when the CSHCS member is enrolled. If the prior authorization is with an OON ancillary provider, MHP will reimburse the ancillary provider at the Medicaid rate through the duration of the prior authorization. Upon expiration of the prior authorization, MHP's prior authorization procedures will be utilized.

MHP will accept prior authorizations in place at the time of transition for non-custom fitted durable medical equipment and medical supplies but will utilize MHP's review criteria after the expiration of the prior authorization. In accordance with Medicaid policy, the payer who authorizes the custom-fitted durable medical equipment is responsible for payment of such equipment.

Record Maintenance
MHP maintains a record of all authorization requests including standard or expedited authorizations requests and any extension of request granted. Records will include:

- Member identifying information (Medicaid ID)
- Request type (standard or expedited)

- Date of original request
- Extension request
- Service code
- Dx code
- Decision made
- Date of decision
- Date the member notice was sent, and if denied, the reason for denial.

REQUIREMENTS AND STANDARDS: MDHHS Transitions of Care Policy

REVIEWED DATE	REVISED DATE	EFFECTIVE DATE
11/17/20	11/17/20	11/17/20
03/16/21	03/16/21	03/16/21
11/16/21	--	11/16/21
03/15/22	--	03/15/22
03/21/23	--	03/21/23
01/16/24	01/16/24	01/16/24