POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Transition of Care
PAGE: 1 of 6	**REPLACES DOCUMENT:** SC.UM.41
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE: 01/2010	**REVIEWED DATE:** 12/09; 01/10; 6/10; 5/11; 5/12; 5/13; 6/14; 11/14; 6/15; 7/16; 12/16; 12/17
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** SC.UM.41.01

SCOPE:
Absolute Total Care Medical Management, Network Management, and Eligibility Departments.

PURPOSE:
Absolute Total Care assists with a member's transition to other care, if necessary, when benefits end, when new members transition into Absolute Total Care, or when a provider terminates their contract with Absolute Total Care.

POLICY:
This policy applies to members:

a. Who are receiving approved services, but whose benefit coverage of services will end while members still need the medically necessary services
b. Who transition into Absolute Total Care and require services that were previously approved via an alternate managed care organization (MCO) or Medicaid Fee-For-Service
c. Whose practitioner plan contract has been discontinued with Absolute Total Care

PROCEDURE:

A. Providing Member Assistance When Benefits End:

1. Absolute Total Care maintains a list of commonly used benefits that have annual or other timeframe limitations titled "Benefits Grid" per the Contract with South Carolina Department of Health & Human Services (SCDHHS). This list is updated as benefits are modified by SCDHHS and reviewed at least annually.

2. Member requests that could not be granted due to benefit limitations are identified during requests for extension of a previously approved service. When this occurs, the Care Manager is notified.

3. Medical Management staff will evaluate the requested services against the number of services prior approved (per TruCare) and available to the member. The Care Manager will consult the requesting practitioner, if necessary, to determine the services remaining that are available to the member.

4. Medical Management staff will refer the request for additional services exceeding benefit limitations to a Medical Director for review to determine if additional services can be approved in accordance with the contract with SCDHHS and the medical necessity guidelines. The decision process will adhere to Utilization Management policy and procedure SC.UM.05 Timeliness of UM Decisions and Notifications.

5. If the Medical Director denies the request, the Care Manager will coordinate efforts with the Program Specialist and notify the member telephonically. The Program Specialist will assist the member in identifying available resources within the local community.

    a. The Care Manager will make at least two (2) telephonic outreach attempts to contact the member.
    b. All attempts and discussion will be documented in the member's TruCare record.
    c. A benefit exhaustion letter (Exhibit A) will be issued to the member and the requesting provider.

6. Absolute Total Care maintains a directory of available community, State and national resources to provide to members in need of additional services when the benefit has been exhausted. The directory is reviewed and updated at least annually.

7. In the event of inpatient hospitalization at the time of transition, Absolute Total Care will continue covering the facility charges until discharge after the transition while the member remains in the hospital.

B. New Members Transition into Absolute Total Care :

1. Upon the receipt of new members, Absolute Total Care will employ several mechanisms to identify those members needing services. These will include, but are not be limited to:

    - MemberCONNECTIONS™ outreach
    - New Member Orientation via telephone and/or face-to-face
    - Referrals from a variety of sources such as Medical Management, Provider Services, Member Services, NurseWise, and Disease Management.
    - Data sources such as claims, encounter data and utilization data
    - Reports from previous Medicaid program or health plan

2. For members needing a continuation of service or for services previously scheduled, the Medical Management staff will work with the member and his/her provider to ensure that those services that are medically necessary can be obtained and there is a continuation of service.
3. If necessary, a Care Manager will be assigned to the member and a transition plan will be developed to ensure that needed services will continue to be provided.
4. An authorization for services shall be entered for medically appropriate services, if necessary.
5. The member shall be transitioned to Absolute Total Care participating providers as soon as medically appropriate and taking into consideration those services that may be accessed without a referral or provided by other community resources.
6. Absolute Total Care also recognizes that pregnant members, regardless of trimester of their pregnancy, will be allowed to continue with their OB/GYN if she chooses to do so. Absolute Total Care will outreach to all pregnant members and assist in accessing care through the Plan "Start Smart for your Baby" prenatal case management program. Absolute Total Care will also ensure the member is educated on the enrollment process.
7. For pregnancy related services, if information is received from a previous Medicaid program or health plan, Absolute Total Care will enter authorizations into authorization system if required, to ensure the member is able to continue with current approved services.
8. For non-pregnancy related services, if a member has authorizations for ongoing or recurring services, the Medical Management staff will communicate with the member and provider to determine the plan of care and need for continuation of those services. Any service that is determined to be medically necessary will be authorized and notification to the provider and member will be made.
9. In the event of inpatient hospitalization at the time of transition, Absolute Total Care's Care Manager will work closely with the member, provider, and facility to assist in discharge planning needs. Absolute Total Care will begin covering the professional charges after the transition while the member remains in the hospital.
10. If a new member has been in active case management, Absolute Total Care's Care Manager will contact the member to perform a risk assessment and develop a plan of care, especially those members identified as:
    - High Risk OB, Teen Pregnancies

- Transplants, Complex/Catastrophic
- Asthma, Diabetes, HIV/AIDS
- Chronic Kidney Disease
- Lead Toxicity
- Sickle Cell

11. In the event a Medicaid member enters Absolute Total Care and is receiving Medicaid covered medical services the day before enrollment, whether such services were provided by another MCO or Medicaid Fee-For-Service, Absolute Total Care will be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. Absolute Total Care will provide continuation of such services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. Absolute Total Care will also honor any prior authorization for medical services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of ninety (90) calendar days after the member's enrollment.

C. Continued Access to a Provider Discontinuing Plan Participation:

1. The Provider Relations Department notifies the Compliance, Eligibility, and Medical Management Departments of a provider termination (Primary Care Provider (PCP) or Specialist).
2. Medical Management receives a report from Eligibility listing members that will be affected by the termination. Medical Management identifies members for continuity of care from claims, prescription, and case management data:

    a. Review the number of visits to practitioner over previous six months
    b. Review “referred to” referrals in TruCare
    c. Review frequency of periodic preventative care provided by same PCP

3. The Care Manager will make at least two (2) telephonic outreach attempts to contact the identified member to discuss the termination of the provider and the opportunity to transition the care to another provider or continue care with the existing provider. Opportunity is given to the member to discuss any other issues regarding the provider termination.

    a. All attempts and discussion will be documented in the member’s TruCare record.

4. Absolute Total Care may also receive a request for continued treatment from a member (or the member's representative) who is receiving active treatment from a terminating provider.
5. Requests are reviewed to evaluate whether they qualify for continuation of care. Continued care with the terminating provider will not be allowed in the following situations:
   a. The member requires routine monitoring for a chronic condition only.
   b. Absolute Total Care has discontinued the contract based on a professional review action (as defined in the Health Care Quality Improvement Act of 1986).
   c. The provider is unwilling to continue to treat the member or to accept Absolute Total Care's payment or other terms.
   d. When a practitioner seen within a group by a member decides to discontinue his or her contract with Absolute Total Care while the rest of the group continues the contract.
6. As appropriate, the member is provided continued care through the postpartum period when in their second or third trimester, or for active treatment of a chronic or acute condition for up to ninety (90) calendar days beginning on the date the contract is terminated, conditioned upon the provider agreeing to the following:
   a. Continue the member's treatment for an appropriate period of time (based on Absolute Total Care goals for the transition).
   b. Share information regarding the provider treatment plan with Absolute Total Care.
   c. Continue to follow Absolute Total Care's Utilization Management policies and procedures.
7. If the request is approved:
   a. An authorization is loaded in the system.
   b. The appropriate Absolute Total Care staff contact the member and provider to notify them of the approval.
   c. The Care Manager will begin discussion with the member and practitioner to develop a plan to transition long-term follow up care to a participating provider.
   d. If the request does not appear to be an appropriate submission, it is reviewed with the Medical Director. If approved, follow steps outlined above. If denied, the appropriate Absolute Total Care staff contact the member to assist them with immediate transition to a participating provider.

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PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** SC.UM.41.01

8. All member outreach attempts and discussion will be documented in TruCare.

REFERENCES:
NCQA Standards and Guidelines
SC.UM.05 Timeliness of UM Decisions and Notifications
CC.PRVR.23 Provider Termination Policy
SC.ELIG.14 Member Notification of Provider Termination
Contract with SCDHHS

ATTACHMENTS:
Benefit Exhaustion Letters-Member and Parent or Guardian (Exhibit A)

DEFINITIONS:

REVISION LOG

REVISION	DATE
Combined policy SC.UM.41 with SC.UM.41.01 to form one Transition of Care policy	1/10
Minor formatting changes, added Network Management and Eligibility departments to Scope section, removed Member Services; Procedure section A #4.clarified Medical Director will review request for additional benefits *exceeding benefit limitations*; clarified that Section C process applies to both PCPs and Specialists; added #3 to Section C.	6/10
Removal of all SCHIP language, Section B #10 added Sickle Cell, Contract Amendment with SCDHHS Medicaid updated to 2011	5/27/11
Minor grammatical corrections; changed NCQA Standards and Guidelines reference to 2012; deleted SCDHHS Standard Contract and Policy and Procedure Guide for SCHIP Managed Care Organizations reference	5/29/12
Updated references from CCMS to TruCare	5/24/13
Annual Review. No changes.	6/27/14
Deleted the word “open’ in bullet #7 page 3.	07/11/14
Updated references	11/17/14
Under Providing Member Assistance When Benefits End added #7. Under New Members Transition into Absolute Total Care #9 added “Absolute Total Care will begin covering the professional charges after the transition while the member remains in the hospital.” Under #11 deleted pharmacy and/or durable medical equipment and added medical.	6/30/15

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Annual Review: Case Manager replaced with Care Manager	07/22/16
Page 4, 11. Changed “sixty (60)” to “ninety (90)” per 7/1/16 Medicaid Contract Corrected Policy Reference name to SC.ELIG.14 Member Notification of Provider Termination Added Benefit Exhaustion Letter (Exhibit A) to the attachment section. Updated attachment to reflect Care Manager.	12/14/16
Page 2, section B-added “Disease Management” to point 3. Page 2, section B-added point 4 “Data sources such as claims, encounter data and utilization data”. Updated “Attachments” to show there are two separate letters-Member and Parent or Guardian.	12/11/17

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Director, Medical Management_____ Date_____

VP Medical Management _____ Date_____