



## **I. Transition of Care Purpose**

The Division of Medicaid (DOM) is the entity charged with administering the Mississippi Medicaid Program. DOM is responsible for the MississippiCAN (MSCAN) Program and the Children's Health Insurance Program (CHIP), which are designed to improve access to necessary medical services, improve quality of care and ensure cost effectiveness. The Transition of Care process ensures continuity of care for beneficiaries that transfer between one coordinated care organization to another, as well as the traditional Fee for Service (FFS) delivery system.

## **II. Transition of Care Requirements**

The purpose of this policy is to satisfy the requirements of 42 C.F.R. § 438.62(b)(3) and is publicly available at <https://medicaid.ms.gov/>.

Coordination Care Organizations (CCOs) shall have a transition of care policy consistent with requirements of 42 C.F.R. § 438.62 Continued services to beneficiaries. CCOs shall make their transition of care policy publicly available and provide instructions to beneficiaries on how to access continued services upon transition. The transition of care policy must be explained to beneficiaries in the materials to beneficiaries in accordance with § 438.10.

## **III. Provider Terminations**

If a beneficiary's Primary Care Physician (PCP), specialist, or other Provider is no longer available to the beneficiary through the CCO network, the CCO must have a plan to ensure continuity and coordination of care and to assist the beneficiary in selecting a network Provider.

Unless the Provider is being terminated for cause, the CCO must allow a beneficiary to continue an ongoing course of treatment from the Provider for up to sixty (60) calendar days from the date the beneficiary is notified by the CCO of the termination or pending termination of the Provider, or for up to sixty (60) calendar days from the date of Provider termination, whichever is greater. A beneficiary is considered to be receiving an ongoing course of treatment from a Provider under the following circumstances:

- a. During the previous twelve (12) months the beneficiary was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized;

- b. An adult beneficiary with a previously scheduled appointment must be determined to be in receipt of an ongoing course of treatment from the Provider, unless the appointment is for a well adult check-up;
- c. Any EPSDT eligible beneficiary with a previously scheduled appointment, including an appointment for well child care, must be determined to be in receipt of an ongoing course of treatment from the Provider; or
- d. A beneficiary who is pregnant may continue to receive care from the Provider that is being terminated through the completion of the beneficiary's postpartum care.

The transitional period may be extended by the CCO if the extension is determined to be clinically appropriate. The CCO must consult with the beneficiary and the health care Provider in making the determination. The CCO must review each request to continue an ongoing course of treatment and notify the beneficiary of the decision as expeditiously as the beneficiary's health condition requires, but no later than two (2) business days. If the CCO determines that what the beneficiary is requesting is not an ongoing course of treatment, the CCO must issue the beneficiary a denial notice.

The CCO must also inform the Provider that to be eligible for payment for services provided to a beneficiary after the Provider is terminated from the network, the Provider must agree to meet the same terms and conditions as participating Providers.

The CCO must notify the DOM in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a specialty unit within a facility and/or a large Provider group) sixty (60) calendar days prior to the effective date of the termination. The CCO must submit a Provider termination work plan and supporting documentation within ten (10) business days of the CCOs notification to the DOM of the termination and must provide weekly updates to this information. In the event a beneficiary entering the CCO, either as a new beneficiary or transferring from another CCO, is receiving medically necessary services in addition to or other prenatal services the day before enrollment, the CCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior authorization and without regard to whether such services are being provided by a Network Provider or non-contract providers.

For medically necessary covered services, the CCO shall provide continuation of such services for up to ninety (90) calendar days or until the beneficiary may be reasonably transferred without disruption to a Network Provider, whichever is less. The CCO may require prior authorization for continuation of services beyond thirty (30) calendar days; however, the CCO is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

#### **IV. Transition of Care Team**

The CCO must have an interdisciplinary TOC team to design and implement the TOC plan and provide oversight and management of all TOC processes. The TOC team will consist of transitional care nurses in

addition to any staff necessary to enhance services for Members and provide support for their return to the home or other community setting.

#### **V. Transition of Care Process**

The CCO will manage and/or assist with TOC and continuity of care for new beneficiaries and for beneficiaries moving from an institutional clinical or inpatient setting, or from a PRTF, back to the beneficiary's home or other community setting. The CCOs process for facilitating continuity of care will include:

- a. Identification of beneficiaries needing transition of care;
- b. Communication with entities involved in beneficiary's transition;
- c. Making accommodations such that all community supports, including housing and other support services, are in place prior to the beneficiary's transition and that treating providers are fully knowledgeable and prepared to support the beneficiary, including interface and coordination with and among social supports and medical and/or Behavioral Health/Substance Use Disorder services;
- d. Environmental adaptations, equipment and other technology the beneficiary's needs for a successful care setting transition;
- e. Stabilization and provision of uninterrupted access to covered services for the beneficiary;
- f. Summary of beneficiary's history and current medical, behavioral health, and social needs and concerns;
- g. Assessment of beneficiary's short-term, and long-term goals, including progress and revision of goals where appropriate; and
- h. Monitoring of continuity and quality of care, and services provided.

#### **VI. Transition of Care Standard Operating Procedure**

1. The DOM submits a twelve (12) month history of FFS medical and pharmacy claims and prior authorization data to the CCO receiving the beneficiary the week after the beneficiary is enrolled.
2. The CCO must determine which beneficiaries are disenrolling from the current CCO for enrollment into another CCO and/or FFS Medicaid.
3. The CCOs must submit the TOC files to the DOM via a secure file transfer. Along with the TOC files, the CCOs must submit copies of the beneficiary's Care Management history, the

most recent six (6) months of claims history, or if the beneficiary has been enrolled with the CCO less than six (6) months, all available claims history, and any pertinent information related to any special needs of any transitioning beneficiaries.

4. The CCO will submit all required information to DOMs Quality Unit no later than the fifteenth (15<sup>th</sup>) day following the month of the beneficiary's disenrollment. The CCO must send all information as available, but no later than the times frames as defined. Some examples of extenuating circumstances are:
  - open enrollment
  - changes by state law for enrollment into the program
5. The CCOs must submit all required information in the format mutually agreed upon by DOM and the CCO.
6. The CCO from which the beneficiary is disenrolling must indicate on the TOC file that this beneficiary has special needs. The CCO when receiving a transitioning beneficiary with special needs is responsible to coordinate care with the CCO from which the beneficiary is disenrolling so that services are not interrupted, and for providing the new beneficiary with service information, emergency numbers, and instructions on how to obtain services.
7. DOMs Quality Unit ensures that the report is received each month.
8. DOMs Quality Unit reviews all submitted information for completeness and evaluates what areas within DOM should receive information related to members transitioning from the CCO to FFS. Some examples are:
  - child with special needs
  - beneficiary enrolling in a waiver program refer to Long Term Care
9. DOMs Quality Unit must conduct periodic audits to ensure continuity of care is being provided for transitioning beneficiaries.