Transition of Care Plan

Overview and Purpose

As a result of the Medicaid Managed Care Final Rules, particularly, 42 CFR 438.62, CMS requires states to have a transition of care plan in place to ensure continued access to services:

- during a transition from fee-for-service to managed care, or
- for managed care organizations planning a merger/consolidation or transferring individuals as a result of a terminated contract or any provider dis-enrolled from a state plan for any reason other than ineligibility for Medicaid.

The purpose of this Transition of Care plan is to ensure continued access to service during a period of transition of individuals, thereby preventing detriment to the individual's health or to reduce risk of hospitalization or institutionalization were the transition policy not in effect. Access to care must be consistent with individual's previous level of care and the individual must have the opportunity to be referred to appropriate in-network providers and retain their current provider for a "period of time" unless health and safety issues warrant otherwise. The individual must transition into the new provider's service delivery system with as little disruption as possible. Providers need to share individual medical records, historical utilization data, and other pertinent information to ensure continued quality services. This Transition of Care Plan has been written for the intent of LME-MCO mergers, however, it could also apply when one provider merges with another. The expectation is that the lead LME-MCO will be responsible for developing and submitting the Transition of Care Plan to DHHS. Implementation of the approved Plan will be the responsibility of the lead LME-MCO.

Below is a listing of the different required elements of the Transition of Care Plan. Each element is described in greater detail in the sections that follow.

1. Communication Plan
2. Care Coordination and Utilization Management
3. Safe Member Transition
4. Credentialing and Re-credentialing of Providers
5. Provider Network
6. Provider Training
7. Services for Individuals
8. Crisis Services
9. Program Integrity
10. Quality
11. Benefit Plan
12. Contract Process
13. Performance Measurement Reporting
14. Facility License Transfers
15. Possession and/or Merger of Records

16. Individual Rights
17. Appeals and Grievances
18. IT Systems
19. Finance

Communication Plan

A critical component of the DHHS Transition of Care Plan is the development of a Communication Plan. Individuals and families must be fully informed of a merger between LME-MCOs. Continued access to services during any transition must be a priority and managed by the implementation of a Communication Plan.

The Communication Plan portion of the Transition Plan for the lead LME-MCO shall be completed and posted on all involved LME-MCO websites in a timely manner.

The required elements of a Communication Plan must include a:

1. Description of the goals of the communication;

2. Description of the stakeholders impacted by this event (i.e., the proposed target audience);

3. Description of the exact message that is to be communicated:
    a. will vary depending on location/makeup of audience (LME-MCO staff members/providers/individuals/family members) being addressed;
    b. will include talking points (internal vs. external talking points);
    c. should be simple and understandable;
    d. should be reflect key administrative functions/departments impacted when addressing LME-MCOs: records transfer, data transfer, procedures, expected timelines;

4. Description of the communication events and activities (i.e., public forums, provider meetings, LME-MCO staff meetings, small meetings with individuals and/or families, webinars, use of interpreters, etc.);

5. Description of methods and frequency of communication (i.e., provide examples, printed publications, promotional materials, media involvement, type of electronic communication to be used, etc.);

6. Description of resources allocated to communication events. (i.e., funding, in-kind contributions, staffing, etc.);

7. Description of how updated information will be communicated to the target audience;

8. Communication Event Schedule to include the type of event/activity, frequency, method of communication, timelines and dates of events; and

9. Listing of Points of Contact and their telephone numbers/email addresses, etc. to manage questions;

The new LME-MCO should ensure that their toll-free number is operative 24/7 and is staffed to handle a high volume of calls during the transition.

Care Coordination and Utilization Management

The LME-MCO Transition of Care Plan must address adequate staffing for care coordination and utilization management during the transition period. The Plan should be completed at least 90 days prior to the transition. Any requests for extensions will need prior approval by DMA.

The transitioning LME-MCO must maintain sufficient care coordination and utilization management staff to ensure adequate support of individuals and management of their services through the contract termination date. The transitioning LME-MCO care coordination and utilization management staff shall work together with the lead LME-MCO staff insofar as is possible to coordinate efforts and use Peer Support Specialists to help wherever possible. The lead LME-MCO must ensure that there is no interruption of services to individuals.

The Transition Plan must:

1. Describe a process for reauthorizations and review of claims and expiring service authorizations for the lead LME-MCO.

2. Include information regarding: current authorizations, medication prescriptions, scheduled appointments, pre-authorization and continuing stay, concurrent reviews and discharge reviews, and monitoring of services.

3. Indicate which staff will be responsible for new service authorization requests during the transition period as requests will need to be processed in a timely manner up to and including midnight of the effective date of transition.

4. Describe how the LME-MCO will ensure that there will not be a lapse in any authorization period.

5. Include staff positions, numbers of FTEs devoted to Care Coordination and UM, and timeline for staff to be fully on board.

Safe Member Transition

The LME-MCO Transition Plan will include the following elements regarding "safe member transition" for the individuals that will be transitioned from one LME-MCO to another:

1. The LME-MCO will monitor the individual transfer process to a contracted provider, ensure provider choice is offered, and that continuity of care and access are provided.
2. Staffing resources will be provided, if warranted, to manage the increase in individuals during the transition period;
3. There should be notification to individuals and families if services have been received in the last 12 months. Notification shall be by letter from the LME-MCO describing the details of the merger and how it will affect the individual and their services. It is expected that the transition plan will discuss how a smooth transition will occur with minimal disruption to current services;
4. There should be a training plan for LME-MCO Care Coordinators regarding their responsibilities during the transition period;
5. The Gaps Analysis will need to be updated to evaluate service availability;
6. All providers that have contracts or will have contracts need to be identified to include phone numbers, locations, and service(s) provided;
7. Individuals and families will be identified and given information regarding crisis services that are available;
8. STR phone lines will need to roll over to the lead LME-MCO;
9. Any agreements with hospitals regarding admissions, discharges, and/or planning will need to be modified;
10. Continuity of care for individuals with I/DD will need to be ensured.;
11. Data will need to be tested, prepared, and transferred to the lead LME-MCO;
12. The lead LME-MCO will ensure safe disposition and transfer of records, including maintenance of confidentiality during the transition period.
13. The LME-MCO will obtain the TCLI In-reach list, review case load assignments and ensure that DOJ settlement activities continue during the transition;
14. The LME-MCO should plan for SIS data transfer;
15. The LME-MCO should update the current Housing Plan to accommodate new individuals;

Credentialing and Re-credentialing of Providers

The agency will include in its Transition Plan a section describing how credentialing and re-credentialing will be handled during the transition period and conducted in accordance with State/DHHS contractual obligations, Federal and State laws, rules and regulations, and LME-MCO accreditation guidelines. Lead LME-MCO shall maintain records of its credentialing and re-credentialing activities with transitioning LME-MCO in order to demonstrate compliance with credentialing and re-credentialing policies and procedures.

The credentialing and re-credentialing section will address the following elements:

1. Documentation using paper files vs. electronic files;
2. An end date for acceptance of applications that are not urgent;

3. Credentialing process during the transition period to include acceptance of current status, reciprocity, and plan to re-credential within a specific timeline indicated in the plan;
4. Monitoring schedule to ensure that all necessary/acceptable providers are "live" at the point of transition; and
5. Historical provider file information (maintained and available for reference purposes if needed).

   Please note: effective July 1, 2018, Providers that have an active record in NC Tracks via the upload process will be required to be re-credentialed via the NC Tracks Provider Enrollment Online Re-credentialing Application.

Provider Network

The Transition Plan must address the various aspects of the Provider Network and must include the following:

1. How and when the provider network will be notified of the planned merger and merger details, including how basic information, such as provider names, types of services delivered by providers, and provider addresses will be shared;
2. Contact information for the lead LME-MCO "points of contact" and a clinical contact staff person for each provider;
3. How the transitioning LME-MCO will share provider files, information regarding gaps or needs in their network, their management plan for addressing those, and information on any providers that are working under corrective action plans;
4. The timeline for the revision and update of the Provider Operations Manual and dates for provider training, and the timeline for providing copies of the manual to transitioning individuals and new individuals prior to the official merger date;
5. Revisions and updates of the Provider Manual to include sections on any new locations of provider (addresses), new or additional phone numbers, changes in services provided by the provider, eligibility criteria if changes have occurred, etc.; and
6. A description of all crisis services, including the types of crisis services, locations, hours, etc.

Provider Training

The Transition Plan will include the following elements regarding a comprehensive Provider Training Plan:

1. Locations of provider trainings;
2. Communication regarding the trainings (bulletins, website, newsletters, etc.);
3. Training topics to include but not be limited to:
   - Purpose, mission, and values of merged LME-MCO or merged provider;
   - Clinical practice standards (including UM/UR, Care Coordination);
   - Contract training requirements;

- Individual rights (including resolution of concerns, problems, disputes, grievances; there is a more detailed section regarding individual rights in a later section of the Transition Plan)

Services for Individuals

The Transition Plan will include a section regarding services for individuals. This section will include the following elements:

1. A description of how the lead LME-MCO will assess service needs and the network of providers that will make up the newly merged LME-MCO. The network must be sufficient to meet the needs of individuals and be in compliance with DHHS access and choice requirements.

2. A description of how the lead LME-MCO will demonstrate significant efforts to increase the provider network and timelines for submitting an exception request when it is identified as not meeting the service access and choice requirements. **The determination will need to be made if any individuals will have to change providers due to disparities in the contracted service array.**

3. A description of how the lead LME-MCO assures that individuals will have free choice of providers within the geographic area and may change providers as needed or desired.

4. The process for determining if an individual needs a specialized service that is not available through the transition to the new network, and how arrangements will be made for the service to be provided outside of the network if a qualified provider is not available.

5. The process for how language and cultural needs of the transitioning individuals will be anticipated and addressed to ensure a smooth and seamless transition.

6. A description of how the lead LME-MCO assures a provider transition plan when providers merge, or a provider becomes disenrolled from a state plan for any reason other than ineligibility for Medicaid, or when a provider transfers individuals as a result of a terminated contract.

Crisis Services

The Transition Plan must include a section that addresses information for individuals regarding available crisis services during the merger and transition.

The Transition Plan will address the following:

1. The documents or materials that the lead LME-MCO will use to share information regarding the crisis services that are available to the individual, including the locations

of the services, the hours, phone numbers, and how questions the individual or family has regarding crisis services will be answered; and

2. The process for developing the crisis plan (how the individual consumer's needs are to be taken into account as an individual is transitioned from one provider to another and one LME-MCO to another). Appropriate interventions based on an understanding of the individual, the individual's preferences, needs, strengths, circumstances, and goals should be a key component of the individual's crisis service plan.

Program Integrity

The Transition Plan should include the following elements regarding Program Integrity (PI):

1. A plan for how the transitioning LME-MCO will continue to monitor and resolve any open cases until the merger is complete.
2. A schedule indicating the remaining open cases that will be triaged 5 business days prior to the official merger date.
3. A timeline for when cases referred to DMA Office of Compliance and Program Integrity under the transitioning LME-MCO will be identified as the responsibility of the lead LME-MCO on the DMA referral to Medicaid Investigations Division.
4. A process that addresses when providers, participating and not participating with the lead LME-MCO, are still in the appeal process.
5. A description of the modification or update of the lead LME-MCO's PI policies and procedures to incorporate 'best practices" policies and procedures of the transitioning LME-MCO.
6. The plan for ensuring state and federal regulations are met as related to PI staffing requirements, to include identification of Regulatory Compliance Officer and other identified PI leadership within the lead LME-MCO.

Quality

The Transition Plan will include the following elements related to quality improvement and assurance:

1. A timeline that includes the completion of a revised Quality Management Plan, if appropriate, as determined by the lead LME-MCO to submit to DMA and DMH/DD/SAS that formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of services delivered.
2. A plan, for reporting purposes, as to when the data from the combined LME-MCOs will be merged.

3. A description of how the new LME-MCO will assess the Quality Improvement Projects (QIPs) and the timelines for such and the projects submitted to DMA and DMH/DD/SAS for approval. The study design for the new or continued QIPs will be expected to meet the requirement of the CMS protocol "Validating Performance Improvement Projects." LME-MCOs need to provide a written summary and an assessment of the effectiveness of the QIPs that are not being continued which will be submitted to DMA and DMH/DD/SAS.

4. The new LME-MCO entity will develop a timeline and process for the transition of NC-TOPPS consumers; directions on mergers/transitions can be found at: https://nctopps.ncdmh.net/dev/GettingStartedWithNCTOPPS.asp or by contacting the Help Desk. The transitioning LME-MCO entity is responsible for ensuring appropriate closure of NC-TOPPS records prior to the transition.

Benefit Plans

The Transition Plan should include a section related to the Benefit Plans services offered to individuals.

- The Benefit Plans' section(s) will include the following elements:
  - The timeline for the current Benefit Plans to be reviewed and updated for the Lead LME-MCO.
  - How and when the updated Benefit Plans will be shared with individuals and family members prior to transition.
  - Provider training on the Benefit Plans and the inclusion of this training in the Training Plan as a topic.
  - A description of the lead LME-MCO's Benefit Plans will be included in the Provider Manual.

Contract Process

As provider contracts are terminated or providers are disenrolled and other providers accept individuals from the terminated or disenrolled providers, the lead LME-MCO will need to manage the contracting process to support the transition. The lead LME-MCO will need to include in its Transition Plan the following:

1. Analysis and planning for the acceptance or non-acceptance of already established provider contracts and single case agreements.

2. Information regarding whether or not provider service expansion will be allowed or additional sites will be allowed during the first year.

3. Analysis of "new to network" provider contracts: review of current agreements, applications in process, and pending renewals or terminations of contracts.

4. A timeline including all related contract tasks, including revising or establishing new contracts, and obtaining appropriate signatures.

5. The communication process that will be followed to inform providers of the contract process during the transition period.

6. A review of Single Case Agreements and "In Lieu of" Services that may be unique to individuals being served by the transitioning LME-MCO; consider special projects/pilots/other initiatives through which individuals may be receiving services.

7. Information regarding whether any providers will be paid on a performance basis or through the use of incentives.

8. Transition budget which reflects in detail planned transition of network related expenses, including the analysis of contract budgets and current financial standing of "new to network" providers.

9. Transition of provider contracts and negotiations of financial terms.

Performance Measurement Reporting

Since Performance Measurement data is submitted a quarter behind to account for claims lag, the lead LME-MCO will submit performance measurement data for each historical LME-MCO in which they operated separately within _____ months of the official merger. Performance Measurement data for the lead LME-MCO will be submitted for dates of service after the merger.

Facility License Transfers

The Transition Plan will need to address expectations related to licensure of facilities during a merger. The Transition Plan will need to address additional licenses and related expenses to on-board new providers. The timelines will be expected to be included in the Transition Plan regarding any facility licensure to be effective prior to the transfer of individuals. The Transition Plan shall address the lack of facility licensure transfer and how that will affect the transition of individuals, the back-up plan, and how services will be maintained for the individuals.

Possession and /or Merger of Records

The Transition Plan must address the possession and/or consolidation of records due to a merger. The elements that must be included in the Transition Plan include:

<u>LME-MCO Merger:</u>

According to the Records Management and Documentation Manual for Providers (Administrative Publication System Manuals or APSM 45-2) from the section entitled, *Transfer of Records when an LME-MCO Dissolves or Mergers*: When an LME-MCO dissolves, the successor organization (lead LME-MCO) **is obligated to assume responsibility** for the records of the dissolved LME-MCO for the duration of the retention schedule for those records per the APSM 10-6. This includes service records, administrative records, and other records covered by the retention schedule.

The Transition Plan must include a description of how and when the lead LME-MCO will assume responsibility for the records of the transitioning LME-MCO. The description shall include information on where the records will be stored and the duration of storage.

Provider Mergers:

In the event that a provider agency ends services in a given region, or dissolves for any reason, the provider is required to arrange to continue the safeguarding of both the clinical and fiscal records per the record retention guidelines; however, if the provider's contract is terminated, the provider may either provide copies of medical records of individuals to the LME-MCO or submit a plan for maintenance and storage of all records for approval by the LME-MCO. The LME-MCO has the sole discretion to approve or disapprove such a plan. The provider is not relieved of the requirement to arrange for continued safeguarding of the original clinical and fiscal records per the record retention guidelines. The plan for maintenance and storage will be included in the Transition Plan.

Abandonment of Records:

The abandonment of records, or any failure of the provider to safeguard the privacy, security, retention, and disposition of records, is a violation of state and federal laws, and is subject to legal sanctions and penalties. The lead LME-MCO must take appropriate action upon notification of any situation where records have been abandoned, exposed, or susceptible to a privacy or security breach. After an investigation by the lead LME-MCO has determined that a violation of health information privacy/security rights has occurred, a formal complaint shall be filed with the Office of Civil Rights [OCR]. When the lead LME-MCO discovers that a provider has abandoned their records, the lead LME-MCO must notify Division of Medical Assistance (DMA) Program Integrity (PI), at 1-800-662-7030, about the abandonment and must contact the provider via registered letter, informing them of their report to DMA PI. The lead LME-MCO shall take possession of the abandoned records and notify the relevant national accrediting organization and all DHHS state agencies involved with the associated provider, including, but not limited to, DMA, DMH/DD/SAS, and the Division of Health Services Regulation [DHSR], in addition to the federal reporting noted above.

The Transition Plan shall describe the process for the lead LME-MCO's investigation and filing a complaint with the Office of Civil Rights.

The Transition Plan will include the process for notification to DMA Program Integrity for the abandonment of records, the process for contacting the provider, and for notifying the appropriate national accrediting organization and all DHHS state agencies.

Individual Rights

The Transition Plan must include an individual bill of rights provision that delineates obligations related to provision of information, respectful treatment, patient engagement in treatment decision-making, access to medical records, and health information privacy. The final rule protects provider-individual communications, including those regarding treatment options and alternatives. The Transition Plan must include information related to how compliance will be assured regarding the Federal and State laws such as Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and Titles II and III of the Americans with Disabilities Act.

(Each individual is guaranteed the right to:

1. Receive information in an accessible manner;
2. Be treated with respect and due consideration for his/her dignity and privacy;
3. Receive appropriate information on available treatment options and alternatives, presented in a manner appropriate to the individual's condition and ability to understand;
4. Receive a copy of his/her medical records and request that such records be amended or corrected;
5. Be furnished health care information which include availability of services, adequate capacity and access to care, coordination and continuity of care, specification and defined coverage of required services;
6. Participate in health care decisions including the right to refuse treatment;
7. Be free from any form of restraint or seclusion used as a means of coercion or discipline; and
8. Not have any adverse treatment by the LME-MCO, network provider or State as a result of exercising their rights.)

Appeals and Grievances

The lead LME-MCO will include in its Transition Plan an explanation of the grievance and appeals process for individuals.

When an LME-MCO denies, terminates or reduces a service, a written notice must be sent to the individual. (The notice must include the following components in a clearly detailed description in plain language:

- The action that the lead LME-MCO has taken or intends to take;

- The type of service or claim that is being denied, terminated or reduced;
- The reasons for the Action;
- The specific federal, state regulations or lead LME-MCO policies that support or require the Action;
- The date the Notice of Adverse Benefit Determination was issued;
- The effective date of the Action if it results in a reduction or termination of ongoing or previously authorized services;
- The individual's right (or provider on behalf of the individual with the individual's written consent) to file an appeal with lead LME-MCO within 30 days; if the lead LME-MCO upholds its original decision, individual or provider on behalf of individual has 30 days from the date lead LME-MCO notice to the individual to file an appeal with the state for a State Fair Hearing;
- The process the individual must follow in order to exercise these rights;
- The circumstances under which expedited resolution is available and how to request for an Appeal or State fair hearing;
- Inform individuals about their fair hearing rights in a manner that assures notice at the time of an action;
- Ensure individuals may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice as required by State policy;
- The Notice of Member Rights;
- A language block in the languages specified by the State of North Carolina;
- A phone number at the lead LME-MCO where individuals may call to obtain information about the Notice of Adverse Benefit Determination, including how to receive a translation of the notice in other languages; and
- The DHHS Customer Service Center toll free number: 1-800-662-7030, for questions that may arise regarding appeals and grievances.)

IT Systems

The Transition Plan will include the lead LME-MCO's process to assessing the following prior to the merger:

1. claims payment system performance of transitioning LME-MCO
2. interfacing and reporting capabilities
3. validity testing of encounter data and IT testing
4. strength of security assurances

If the merged agencies include two distinct information systems that were developed on different platforms, the lead LME-MCO must take ownership of the data from the transitioned LME-MCO. If there are differences that may limit the lead LME-MCO's ability to submit encounter

data in a timely manner, and within the 95% approval rate for encounter data (on a monthly basis), DMA must be alerted to this issue 90 days prior to the merger.

Finance

The Transition Plan will be expected to include a financial component that minimally reflects the following areas, with specific planning components as necessary for pre & post transition activities as appropriate:

1. Analysis and planning for any outstanding payables and receivables for network;
2. Identify any outstanding provider debt obligations with settlement/audits and designating responsible party which will assume liability;
3. Analysis and planning for any impact of current or planned provider incentives;
4. Analysis and planning for existing pilot projects;
5. Analysis and planning for cost of marketing new network to the increased geographic population served;
6. Impact to any network operations related service contracts;
7. Planning for any differences in provider payment schedules;
8. Planning for any potential of provider advance payments during transition;
9. Training for all new to network providers for billing and finance processes;
10. Identification of any existing or potential provider litigation;
11. Coordinate with state for CDW conversion and NC Tracks CNDS (Common Name Data Service) numbers as needed;
12. Coordinate transition of NC TOPPS;
13. Analysis of any network provider investigations that could have any potential financial impact to the organization and/or potentially limit provider selection for individuals;
14. Status of required audits and plan to complete any necessary provider audits pre and post-merger;
15. Identification of any installment debts;

16. Any needed change in billing information, application for funding sources provider numbers due to any change in organizations legal name or bi-laws. (Medicaid, Medicare, Private Carriers, self-pay, etc.);

17. NC Tracks change over: Local ID, NPIs, Provider Contract Segments, outstanding claims/RA, NC Tracks security;

18. NC Tracks: LME-MCO merger:

    a. Recipient eligibility and enrollment
    b. Any LME-MCO specific rates, provider rates, and recipient specific rates
    c. Prior Authorizations especially for 3-way contracts
    d. Prior Authorizations (non 3-way contracts)
    e. Regular security and access for LME-MCO and provider's office manager roles for NC Tracks…operations portal and provider portal
    f. Process for clean-up of outstanding or otherwise aged claims (and related activities)
    g. Budgets to handle payment of outstanding claims
    h. Transition of provider records to remaining LME-MCO

19. If necessary, new IRS Tax Identification number;

20. Analysis of outstanding claims for new to network providers;

*21. Analysis of existing or requested state service rates across merging networks**

*22. Identify special allocations for any consumer/provider and related planning**

*23. Changes to grant award requested from Grantor agency if necessary**

*24. New to network FSR billing**

*25. Review any transitioning LME-MCO grants: current agreements; applications in process; pending renewals or terminations for potential impact on services, providers or overall network**

*26. Identify and plan for transition of any assets held by transitioning LME MCO or providers which were purchased with state or federal funding**

*27. Any special reporting required by funding source is continued by providers and or lead LME-MCO (some examples: pilot project reports; SAMSHA grants; TCLI)**

**Items 1-27 typically are solely related to DMA/Medicaid covered lives in network but can also be applicable to state funded consumer within the LME-MCO networks; items*

21-27are exclusive to state funded individuals. However, due to the fact that individuals can and do receive separate services which are supported by both Medicaid and state funding, care should be given to address all points in the transition plan.

Looking Ahead

The final rule on Medicaid managed care is a milestone in Medicaid's ongoing modernization as the delivery systems that serve Medicaid beneficiaries continue to evolve. In keeping with states' increasingly heavy reliance on managed care plans to provide care for millions of Medicaid individuals, including many with complex care needs and special vulnerabilities, the regulatory framework and state and plan requirements established by the final rule reflect increased federal expectations regarding fundamental aspects of states' Medicaid managed care programs. At the same time, the rule seeks to strike an appropriate balance between federal minimum requirements and state flexibility to determine specific standards and processes. In the months and years ahead, CMS, states, managed care plans, individuals, providers, and other stakeholders will be focused on implementation of the provisions of the new rule and its impact on the quality of care, support and experience of care, and innovation and value in Medicaid managed care programs.