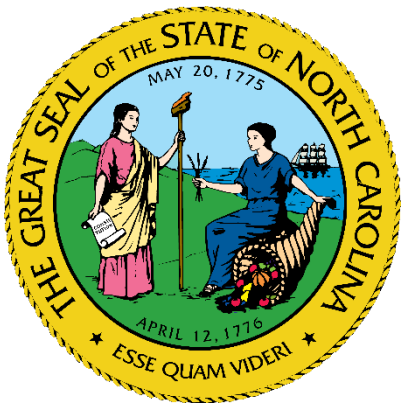

NC Department of Health and Human Services

Transition of Care Protocols

Transitions between Standard Plans and LME/MCOs

Transition of Care Protocols:
Transitions between Standard Plans and LME/MCOs

Change Log		
Version	**Posting Date**	**Updates/Change Made**
1.1	8/20/2021	Initial Posting, effective date 7/1/2021, updated 7/13/2021

Table of Contents

I. General References

A. Transition Scenarios Covered by this Protocol

The *Transition of Care Protocols: Transitions between Standard Plans and LME/MCOs* ("the Protocol") governs how NC Medicaid-enrolled individuals who are "Tailored Plan-eligible" (also referred to as "Standard Plan Exempt") will transition between the Standard Plans and the LME/MCOS. This Protocol includes specific information for the following scenarios:

1. Standard Plan Member identified as *Tailored Plan-eligible* through the Request to Move process and transitions to the LME/MCO.
2. Standard Plan Member identified as *Tailored Plan-eligible* through Department's data review process and transitions to the LME/MCO.
3. Additional notes provided for Standard Plan Members disenrolling due to state hospital or ADATC admissions and for Members enrolling in Transitions to Community Living Initiative (TCLI).
4. *Tailored Plan-eligible* LME/MCO Enrollees who transition to a Standard Plan on or after July 1, 2021.

B. Protocol Limitations and Clarifications

1. This Protocol applies to Standard Plans and LME/MCOs that are operational on July 1, 2021. It does not apply to future Tailored Plans or to future transitions between the Standard Plans and Tailored Plans. The Department will develop and issue revised Protocols at a later date to reflect transitions between the Standard Plans and Tailored Plans.

2. The Protocol refers to individuals enrolled in a Standard Plan as "Members." For clarity, individuals enrolled in an LME/MCO are referred to as "Enrollees."
3. Transitions during Crossover period (activities related to LME/MCO Enrollees transitioning to Standard Plans on July 1, 2021 are governed by Crossover- specific protocols and are not reflected here.
4. This Protocol does not provide guidance on payments or reimbursements related to transitions between Standard Plans and LME/MCOs.
5. While the Protocol references eligibility-related processes , it should not be used as source document for the Department's 834/GEF or Medicaid eligibility policy.
6. Transition of Care requirements related to data file transfer are established in the Transition of Care Data Specification Guidance.
7. Please also see requirements established in contract and in NC DHHS Transition of Care Policy, including *Appendix B: Transition of Care: Special Considerations for Supporting Members Who May Meet Tailored Plan Criteria*
8. This Protocol applies to those individuals who are transitioning between the Standard Plan and the LME/MCO. While the process may be similar, this Protocol does not address Standard Plan Members who are excluded from the LME/MCO population scope, such as children disenrolling due to Tailored Plan eligibility who are 0-3 or enrolled in NC Health Choice.

C. Definitions

For additional description, please see relevant contract definitions and NC DHHS Transition of Care Policy.

1. **Advanced Medical Home Tier 3** (AMH Tier3): Primary care practices under contract with one or more Standard Plans and that adhere to the Department's Advanced Medical Home Model. AMH Tier 3s assume responsibility for care management for Standard Plan Members in most, but not all cases.
2. **Notice Date:** The date the individual's pending transition is first reported on the Standard Plan eligibility file (834) or the LME/MCO eligibility file (GEF).
3. **"Off Cycle:"** Transitions which occur at a time other the first of the month following the eligibility file notice date.
4. **PHP Contract Data Utility (PCDU):** NC DHHS platform through which transition information is transferred between the Standard Plans and LME/MCOs.
5. **Request to Move:** The process through which Standard Plan Members who are not identified as meeting Behavioral Health I/DD Tailored Plan eligibility criteria as part of the DHHS data review process but meet one of the criteria outlined in relevant legislation can submit to DHHS a request to stay in NC Medicaid Direct/LME-MCO. The request can be made using one of the forms described in this Protocol.
6. **Tailored Plan-Eligible:** An individual who meets the criteria for remaining with or transitioning to the LME/MCO after July 1, 2021.
7. **Transition File:** Individual-specific information provided by the transferring entity to the receiving entity.
    - Standard Plan-generated Transition File includes:
        - Care needs screening;

        - Care plan if applicable;
        - PHP Ongoing Transition of Care Transition Summary;
        - Appeals Transition Summary Form;
        - Additional information the Standard Plan deems necessary to ensure continuity of care.
    - LME/MCO-generated Transition File includes:
        - LME/MCO Ongoing Transition of Care Transition Summary
8. **Transition Summary page:** A summary of transitioning individual's current status on topics reflected in the applicable Transition Summary page template. Topics include current providers and services, urgent socio-clinical needs and other information as provided in the template.
9. **Warm Handoff:** a brief "knowledge transfer" discussion between the Standard Plan and LME/MCO about a transitioning individual.

D. Designated Receiving Entity for Standard Plan Members Transitioning to LME/MCO

1. The Receiving Entity for Standard Plan Member Transitioning to the LME/MCO is the LME/MCO for Member's County*[1]
2. This is referred to as County of Residence in Medicaid Eligibility policy but referenced as "Medicaid administrative county" on eligibility data files.

E. Applicable Workflows

1. BP-EE01-2 Conduct Redeterminations

II. Overview of Pathways to Tailored Plan Eligibility

Standard Plan Members may be identified as Tailored Plan-eligible (and therefore authorized to transition to an LME/MCO) through one of two primary pathways:

1. Through the Department's *Request to Move* process; or
2. Through the Department's Data Review.

A. *Request to Move* Process Pathway Description

1. The *Request to Move* process can begin in either of two ways:
    a. A Member can submit the *Request to Move to NC Medicaid Direct or LME-MCO: Beneficiary Form*; or

[1] From MA-2221: DETERMINING COUNTY RESIDENCE A. Non-institutional Living Arrangement An individual has residence in the county in which he lives. This applies even if the individual owns a home in a different county or state. B. Institutional Living Arrangement An individual in a hospital, mental institution, nursing facility (SNF, ICF-MR), Adult Care Home (rest homes/domiciliary care facility/assisted living) or a similar institution/facility: 1. Is a resident of the county in which he lived immediately prior to entering the facility. 2. If an individual moves from another state directly into an institutional living arrangement, the individual is a resident of the county in which the facility is located. If the individual moves to more than one institution/facility, the county of residence is the county where the first institution/facility is located. NOTE: Residence in an adult care home does not establish county residence, even when the individual was a private paying adult care home resident. Establish his county of residence prior to entering the adult care home.

b. A provider can submit the *Request to Move to NC Medicaid Direct or LME-MCO: Provider Form.*

2. Within the Request to Move mechanism, the request may be:
    a. A Non-Service Associated Request: a request that does not include a service authorization request (SAR) for services either submitted directly by either a Member or by a provider with the Member's consent; or
    b. A Service-Associated Request: a request submitted by a provider with the Member's consent, requesting specific services only available through the LME/MCO for Members who require behavioral health, substance use, intellectual and developmental disability or traumatic brain injury supports not available in the Standard Plan. Service-Associated Requests to Move are typically accompanied by a Service Authorization Request (SAR), the mechanism used to request prior authorization of the relevant service.
3. Standard Plan care managers (either directly through the Standard Plan or AMH-Tier 3) may not submit a Request to Move on a Member's behalf but are expected to assist the Member in understanding this option and may assist the Member through the request process.
4. Additional Information about these Tailored Plan Eligibility Pathways can be found here:
    a. Behavioral Health I/DD Tailored Plan Memo on Eligibility and Enrollment Updates, February 2, 2021
    b. As of the Protocol's release date, the referenced forms have not yet been posted. When published:
        i. The electronic version of the forms that providers/Members can submit via Adobe Sign will be here: https://www.ncmedicaidplans.gov/submit-forms-online

        ii. The PDF version of the forms will be here: https://www.ncmedicaidplans.gov/member-resources

B. TOC Guidance related to General "Requests to Move" Processes

1. Due to the rapid, "off cycle" disenrollment dynamic under Service-Associated Request to Move scenarios, the Member's Standard Plan is expected to have internal protocols in place to identify Members who have requested the transition, in order to prepare for the transition in advance of the 834 Notice Date.

2. Request to Move forms effective on July 1, 2021 will incorporate 42 CFR Part 2 consent language in order to promote the effective communication between the Member's Standard Plan and LME/MCO at the time of transition.
3. A Member's involuntary commitment status does not impact the Request to Move process or related clinical standards for securing consent prior to submitting Request to Move forms.

C. Additional Specific Guidance about Non Service-Associated Requests to Move

1. The provider or member will submit Non-Service Associated Requests to Move through the Enrollment Broker.
2. Approved Non-Service Associated Requests to Move will be processed on the timeframes established below and will result in the Member's disenrollment on the first of the following month.
    a. Within five (5) business days of submission of *Request to Move to NC Medicaid Direct or LME-MCO: Provider Form* .
    b. Within eight (8) business days of submission of *Request to Move to NC Medicaid Direct or LME-MCO: Beneficiary Form*.

D. Additional Specific Guidance about Service-Associated Requests to Move Form

1. Service-Associated Requests to Move will result in the Member's disenrollment from the Standard Plan, aligned with the following timeframes:
    a. Within 24 hours of provider's submitting a Service-Associated Request to Move form, the Enrollment Broker sends the Service Authorization Request (SAR) and supporting materials to the applicable LME/MCO, notifies the Standard Plan using email addresses provided and forwards the request to the Department's eligibility team for processing.
    b. Within one (1) business day of receipt, the Department's eligibility team updates the Member's eligibility.
    c. The day after the eligibility evidence has been updated, the Notice Date is reflected on the 834/GEF.
    d. Disenrollment is retroactively applied back to the request date.
    e. **Notice of Crossover, Time-Limited Modification:** For the month of July, Service Associated Request to Move forms will be retroactively applied back to the first of July, 2021.
2. For requested services requiring a clinical assessment, the Standard Plan will support pre-disenrollment assessment activity by reimbursing the provider for assessments necessary to complete and submit the related SAR.
3. As a result of the process described above, the Enrollment Broker will notify the LME/MCO and the Standard Plan of the Standard Plan Member's pending disenrollment prior to the disenrollment being reflected on the GEF/834.
4. A Member with a valid Service-Associated Request to Move form will disenroll from the Standard Plan and enroll in the LME/MCO, regardless of the LME/MCO's final determination for the underlying SAR.
5. The LME/MCO is required to adhere to the SAR processing timelines as established in the LME/MCO's contract with the Department. The timeline starts on the Enrollee's enrollment date with the LME/MCO.
6. Requests for SAIOP and SACOT services may be requested through the Service-Associated Request to Move process despite no underlying authorization request requirement due to available pass through options.
7. Due to the retroactive disenrollment resulting from Service-Associated Request to Move process, the Standard Plan must make a good faith effort to conduct a Warm Handoff and

transfer the Transition File for Members transitioning under this scenario prior to Member's disenrollment date and no later than the Member/Enrollee's Notice Date.

E. Specific Guidance for Members Disenrolling due to State Operated Health Facility Admission

1. Admissions to state psychiatric hospitals and ADATCs do not result in the Member's immediate automatic eligibility change.
2. With the Member's consent, the state psychiatric hospital or ADATC will submit the Request to Move form for those Members who have been assessed by their DSOHF treatment team to require a Tailored Plan-only service upon discharge. This will activate an off-cycle disenrollment retroactive to the date of the request, comparable to the Service-Associated Request to Move process.
3. State psychiatric hospitals and ADATCs will not submit Request to Move forms in any other circumstance.
4. For those transitions activated by the facility's submission of the Request to Move form and if not previously notified by the state psychiatric facility, ADATC or the LME/MCO directly, the Standard Plan will initiate Transition File transfer and Warm Handoff activity upon receiving notice from the Enrollment Broker of the form's submission. Transition activities in this circumstance will occur no later than the Member's disenrollment date or 834 Notice Date, whichever occurs later.
5. For all other transitions, the Standard Plan will ensure the Warm Handoff and Transition File transfer occurs no later than the Member's disenrollment.
6. The Standard Plan will hold its Warm Handoff session with the Member's LME/MCO.
7. The Member's care manager, whether within an AMH-Tier 3 or directly at the Standard Plan, is expected to participate in admission-related care planning.

F. Additional Guidance about Members identified as "Tailored Plan Eligible" Through Data Review Process

1. The Department will conduct a monthly analysis of Standard Plan encounter data to identify members who meet the criteria established in *CRITERIA FOR Behavioral Health I/DD TAILORED PLAN EXEMPTION FROM MANDATORY ENROLLMENT IN NC MEDICAID STANDARD PLANs Appendix B (as revised).*
2. The Department will update the managed care status code for Standard Plan Members identified through this mechanism, and this status change will be reflected on the 834 and GEF.
3. The Member will automatically disenroll the first of the following month.
4. If a Member is disenrolled from the Standard Plan under this process, the Member may be elect to transition back to Standard Plan through a request to Enrollment Broker. Once this transition has occurred, the Member's eligibly status will enable the Member to remain with the Standard Plan and the Member will not be impacted by future data queries.

G. Specific Guidance for Members Disenrolling Due to Enrollment in Transitions to Community Living Initiative (TCLI)

1. Overview of TCLI Enrollment Process

a. For a full description of TCLI, see NC DHHS Transitions to Community Living webpage.

b. All Standard Plan Members seeking admission to an Adult Care Home (ACH) must also have a referral submitted through Referral Screening Verification Process (RSVP). The RSVP may be submitted directly by the ACH or by the Standard Plan.

c. For full instruction on RSVP process, Standard Plans can refer to *PHP Referral Screening Verification Process (RSVP) Training.*[2]

   i. If the Member does not have indication of SMI/SPMI, the Department will not forward the referral to LME/MCO and TCLI-related process ends.

   ii. If the Member's referral indicates SMI/SPMI, the Department will forward the Member's information to LME/MCO for screening.

d. If the RSVP referral for a Standard Plan Member results in the LME/MCO's screening and confirmation of TCLI eligibility, the LME/MCO will report the Member's information to the Department's TCLI management team who will advance it to NC Medicaid as being "eligible" in TCLI program.

   i. A Member is considered "eligible" in TCLI if the Member meets TCLI clinical criteria.

   ii. A Member will be considered TCLI-eligible even if the Member has not yet decided to transition from the Adult Care Home under TCLI.

e. TCLI-eligible Members are projected to disenroll from the Standard Plan and enroll in the LME/MCO, effective the first of the month following the evidence being entered. If a Standard Plan Member is identified as TCLI eligible and through the screening, it is determined the Member wishes to remain in the Standard Plan, the LME/MCO will communicate this to the Department following instruction to be provided at a later date.

2. Coordination with other Entities on RSVP Submission

a. The Standard Plan is expected to coordinate with Adult Care Homes and community hospitals in RSVP submissions to avoid duplicative submissions.

3. **Coordination with LME/MCO on Potential TCLI Members**

a. The Member's pending LME/MCO may reach out to the Member's Standard Plan for assistance in securing additional clinical information necessary to determine TCLI eligibility.

[2] Provided to Standard Plans on May 11, 2021 and available through PCDU.

III. Application of Standard Plan Transition of Care Requirements to this Protocol

A. General Requirements

1. **Notice of Crossover, Time-Limited Modification:** On 6/29/2021, to accommodate trends related to the warm handoff process, the State, Standard Plans and LME/MCOs jointly agreed to extend the Crossover-related Warm Handoff and File Transfer schedule through 8/31/2021.
2. The Member's Standard Plan is responsible for activating Transition of Care process requirements upon learning of the Member's anticipated disenrollment. To best ensure Member continuity of care, this activation should precede the 834 Notice Date wherever practicable.
3. The Member's anticipated LME/MCO may become aware of the Member's upcoming transition before the evidence is reflected on the 834. The LME/MCO, upon learning of the pending transition, will notify the Member's Standard Plan if it has not otherwise been contacted by the Standard Plan directly.

B. Protocol-Specific Guidance on Transition of Care Requirements for Members Disenrolling to LME/MCO

1. **Warm Handoff Process:**
    a. Standard Plan Warm Handoff timelines are established in the NC DHHS Transition of Care Policy. However, because of the expedited disenrollment scenarios outlined in this Protocol, a Standard Plan is expected to initiate Warm Handoff *scheduling* upon learning of the Member's anticipated disenrollment (i.e. within one business day).
    b. For disenrollments activated by the Service-Associated Request to Move process, the Warm Handoff should occur by the Member's disenrollment date or 834 Notice Date, whichever occurs later.
    c. For all other disenrollments covered under this Protocol, the Standard Plan shall follow the NC DHHS Transition of Care Policy with a warm handoff occurring no later than the Member's transition date.
    d. The Transition Summary, which the Standard Plan will develop for every disenrolling Member under this Protocol, outlines key topics for any Warm Handoff.

c. Additional Protocol-specific Warm Handoff Briefing Topics:

i. Discussion of Out-of-Network Provider Status: Because a Member is disenrolling to a closed network, the Member's current behavioral health provider may not be currently enrolled in the LME/MCO network. The Standard Plan and LME/MCO should confirm any out-of-network provider status as part of the Warm Handoff .

ii. Open Behavioral Health appeals with Continuation of Benefit impact: As part of the Member's Transition File, the Standard Plan will provide a summary of any outstanding adverse benefit determinations that may impact

service continuity in order to ensure seamless continuation of benefit on any service covered by both the Standard Plan and the LME/MCO.

iii. **Additional clinical complexities:** The Standard Plan should alert the LME/MCO of non-behavioral health clinical complexities or circumstances that will require the LME/MCO to coordinate with other entities to ensure post disenrollment coordination of care. Examples include: having conditions or circumstances that warrant CCNC care management; Member currently care managed by CMARC or CDSA; Member has pending foster care enrollment.

2. **Consent under 42 CFR Part 2**
   a. Prior to transferring the Transition File or conducting a Warm Handoff, the Standard Plan is expected to secure LME/MCO-specific consent from the Member if Member/services are covered under 42 CFR Part 2.
   b. If the LME/MCO seeks additional information on a former Standard Plan Member for whom 42 CFR Part 2 applies and for whom consent has not otherwise been secured, the LME/MCO will secure Standard Plan-specific consent before requesting additional information.

3. **Transition File Transfer**
   a. The required content of the Standard Plan's Transition File is established in the NC DHHS Transition of Care Policy.
   b. For disenrollments due to Service Associated Request to Move process, the Standard Plan will transfer the Member's transition file by occur by the member's disenrollment date or 834 Notice Date, whichever occurs later.
   c. For all other disenrollments covered under this Protocol, the Standard Plan shall follow the NC DHHS Policy with transition file transfer to occur no later than the Member's disenrollment date.
   d. All file transfers between the Health Plan and LME/MCO will be managed through the PCDU process and related technical requirements.

4. **Preparing Members**
   a. General requirements of Standard Plans for preparing Members are established in the NC DHHS Transition of Care Policy.
   b. The Standard Plan will advise Members on anticipated changes to currently authorized services resulting from the transition.

5. **Preparing Providers**
   a. General requirements of Standard Plans for preparing providers are established in the NC DHHS Transition of Care Policy.
   b. A Member transitioning into the LME/MCO is transitioning into a closed network. As part of TOC coordination, the Standard Plan should confirm the LME/MCO network status of the behavioral health providers that currently serve the member under the Standard Plan behavior health service scope and direct provider to LME/MCOLME/MCO resource for managing out-of-network providers.

6. **Guidance on Coordination with Other Entities Necessary to Ensure Continuity of Care**
    a. General requirements of Standard Plans for coordinating with other entities are established in the NC DHHS Transition of Care Policy.

IV. Guidance for Medicaid Direct/Standard Plan Exempt Beneficiaries Transitioning to Standard Plan Option after July 1, 2021

A. Summary of Standard Plan Enrollment Process

1. A Standard Plan-exempt Enrollee served by the LME/MCO who wishes to transition to a Standard Plan activates the process through the Enrollment Broker.
2. The transition will take effect the first of the following month the eligibility evidence is entered.

B. LME/MCO Prior Authorization Data File Transfer

1. The LME/MCO's Prior Authorization (PA) data file transfer will activate following *Requirements for LME-MCOs to Share Transition of Care Information to support Continuity of Care for Members transitioning between LME-MCOs & Standard Plans*.
2. If the Standard Plan has not received the transitioning Member's PA file from the LME/MCO within five (5) business days of the 834 Notice Date, it will notify the LME/MCO within one (1) business day.

C. Warm Handoff

1. The LME/MCO is responsible for initiating a Warm Handoff with the transitioning Enrollee 's upcoming Standard Plan.
2. The LME/MCO will coordinate a Warm Handoff for each Standard Plan-exempt Enrollee who has received a Tailored Plan-only services in the six months prior to disenrollment date and elects to transition to a Standard Plan.
3. To ensure information is current upon transition, the LME/MCO and Standard Plan will have the flexibility to hold the Warm Handoff on any time mutually agreed upon prior to the Enrollee's transition date.

D. Securing Consent under 42 CFR Part 2

1. The LME/MCO is required to make a "good faith" attempt to secure consent in order to communicate any information covered by 42 CFR Part 2.
2. If an LME/MCO cannot secure the necessary consent, it will instruct the impacted provider to resubmit any current impacted authorizations to the Enrollee's new Standard Plan.
3. If the Standard Plan seeks additional information on a Member for whom 42 CFR Part 2 applies and for whom consent has not otherwise been secured, the Standard Plan will secure a consent specifying the LME/MCO before requesting additional information.

E. Transition File Content and Transfer

1. LME/MCO Transition File content will include minimally a Transition Summary that includes information about open appeals.
2. To ensure information is current, the LME/MCO may transfer the Transition File to the Standard Plan up to the Enrollee's disenrollment date.
3. All file transfers between the Standard Plan and the LME/MCO will be managed through the PCDU process and related technical requirements.

F. Support to Transitioning Members

1. The LME/MCO will advise the Enrollee if any material changes to services will result from the transition.

G. Support to Transitioning Providers

1. The LME/MCO will notify providers with active authorizations that may be discontinued as a result of the transition.

H. Follow Up

1. LME/MCOs will follow up with the Enrollee's/Member's Standard Plan after the transition to confirm information was received and to brief on transition-related issues.

I. Additional Related Standard Plan Responsibilities

1. As noted in the NC DHHS Transition of Care Policy, Tailored Plan-eligible Members who remain in or return to the Standard Plan shall be designated by the Standard Plan as a Priority Population for Care Management under the Adults and Children with Special Healthcare Needs categories.