Medicaid Managed Care
Policy Paper

Transition of Care Policy

North Carolina Department of
Health and Human Services

February 25, 2021

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NC Department of Health and Human Services Transition of Care Policy

I. Background

As beneficiaries move between delivery systems, including between health plans, the Department of Health and Human Services (Department or DHHS) intends to maintain continuity of care for each Member and minimize the burden on providers during the transition.

-NC Department Health and Human Services published intent for Transitions of Care

A Medicaid beneficiary's transition between service delivery systems, including between health plans, poses unique challenges to ensuring service continuity and effective coordination between responsible entities. Transition of Care (TOC) activities applicable to NC's Medicaid Managed Care program are governed by both regulatory and statutory requirements.[1] The Department established its TOC requirements for Standard Plan "Prepaid Health Plans" (PHPs) in its *Request for Proposal 30-190029-DHB*. The NC DHHS Transition of Care Policy aligns with and supplements the requirements established in *Request for Proposal 30-190029-DHB, and* subsequent amendments.

II. Scope

While other entities may work under comparable requirements, the scope of this Policy is limited to Transition of Care requirements for Medicaid Managed Care Prepaid Health Plans. Accordingly, Medicaid beneficiaries are referred to as "Members."

Further, the Department will release Disenrollment Protocols to further clarify requirements and processes referenced in this Policy.

Nothing in this Policy shall be construed to limit, amend, or reduce requirements established in the Standard Plan PHP contracts. Any conflict between this policy and a Standard Plan contract shall be determined in favor of the contract.

[1] See Relevant Legislation section of this Policy

Although the PHP has the authority to delegate activities under this Policy to Tier 3 Advanced Medical Home/Clinically Integrated Network Organizations, the PHP remains responsible for oversight to ensure delegated entities meet transition of care requirements.

This Policy governs the PHP practices related to Transition of Care and covers four broad Transition of Care topics:

- *Transition of Care at Managed Care Launch ("Crossover")*
  "Crossover" refers to the Department's conversion to a managed care service delivery system. Transition of Care at Crossover-specific requirements are time-limited and established in Appendix A of this Policy.

- *Ongoing Transition of Care*
  Processes related to supporting Members to transition between PHPs or between service delivery systems, including disenrollment.

- *Preliminary requirements for assisting Standard Plan PHP Members who may be eligible for Tailored Plans.*
  These preliminary requirements are included in Appendix B of this Policy.

- *Transitional Care Management Requirements*

III. Policy Statement

A. General Transition of Care Requirements

1. The PHP shall develop policies, processes, and procedures to support Members transitioning between PHPs or between delivery systems.
2. The PHP shall identify enrolling or disenrolling Members, as defined in the Managed Care Enrollment Policy, who are transitioning from or to another PHP, Medicaid Fee-for-Service/ Local Management Entity/Managed Care Organization (LME/MCO) or the Tribal Option.
3. For all Members transitioning from the PHP, the PHP shall transfer the information necessary to ensure continuity of care, including appropriate Transition of Care data files and Member-specific socio-clinical information.

    a) The PHP shall facilitate the transfer of Member's claims/encounter history, and Prior Authorization data between PHPs and to other authorized Department Business Associates following the data transfer protocols established by the Department and in accordance with related contract and privacy and security requirements.

    b) Transferred Member-specific socio-clinical information is also referred to as the Member's transition file. A Member's transition file content may vary based on the Member's circumstance but shall minimally include:

        (1) The transitioning Member's most recent care needs screening;

(2) The transitioning Member's most recent care plan (for transitioning care managed Members and Member disenrolling from the Standard Plan Option, if available;
(3) List of any open adverse benefit determination notices for which appeal timeframe has not yet expired and the status of open appeals;
(4) A Transition of Care Summary Page for each Member identified for a warm handoff and all Members disenrolling from the Standard Plan Option. This summary page includes minimally:
    (a) List current providers;
    (b) List of current authorized services;
    (c) List of current medications;
    (d) Active diagnoses;
    (e) Known allergies;
    (f) Existing or prescheduled appointments (including Non-Emergency Medical Transportation (NEMT), as known;
    (g) any urgent or special considerations about a Member's living situation, caregiving supports, communication preferences, or other Member-specific dynamics that impact the Member's care and may not be readily identified in other transferred documents.
(5). Additional information as needed to ensure continuity of care.

4. Unless otherwise specified in this Policy or applicable protocols, the PHP shall adhere to the following timeframes related to transition data and transition file content transfer:
    a) Within five (5) business days of the PHP receiving notice that a Member will disenroll, the PHP shall transfer transition data files to the applicable PHP or receiving entity.
    b) The PHP shall initiate a warm handoff, if required or warranted, and transfer the Member's transition file to the applicable PHP or receiving entity on a timeline appropriate to the Member's circumstance but occurring no later than the Member's transition date.
    c) If a PHP receives notice of a transitioning Member's enrollment and has not received the applicable transition data file or the Member's transition file within five (5) business days of the transition notice date, the PHP will contact the applicable entity on the following business day to request transition information as needed.

5. Upon receipt of the relevant Member information, the beneficiary's new PHP shall ensure that all data as defined by the Department, once received, are transferred to the Member's Advanced Medical Home Tier 3 or CIN up to 30 calendar days prior the effective date and no later than 7 business days of the effective date of the PHP's assignment of the Member.
6. The PHP shall ensure that any Member entering the PHP is held harmless by providers for the costs of medically necessary covered services except for applicable cost sharing.
7. The PHP shall allow a Member to complete an existing authorization period established by their previous PHP, LME/MCO or Medicaid Fee-for-Service entity.
8. The PHP shall assist the Member in transitioning to an in-network provider at the end of the authorization period if necessary.
9. The PHP shall, in instances in which a Member transitions into a PHP from Medicaid Fee-for-Service, another PHP, or another type of health insurance coverage and the Member is in Ongoing Course of Treatment or has an Ongoing Special Condition permit the Member to continue seeing his/her provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d)-(g).
10. The PHP shall allow pregnant Members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the end of pregnancy, or loss of eligibility.
11. The PHP shall bear the financial responsibility for diagnosis-related group based inpatient facility claims of an enrolled Member who is admitted to an inpatient facility while covered by the PHP (or prior in the case of a beneficiary who is inpatient on their first day of enrollment in the PHP if there is no prior Medicaid managed care or fee-for-service coverage for inpatient) through the date of discharge from such facility. Post discharge care may be coordinated prior to discharge.

B. PHP Transition of Care Policy Content Requirements

1. The PHP shall establish a written PHP Transition of Care Policy. The PHP Transition of Care Policy shall include, at a minimum, the requirements in 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii), and processes and procedures for:
    a. Coordination of care for Members who have an Ongoing Special Condition;
    b. Coordination of Members transitioning from Medicaid Fee-for-Service into the PHP;
    c. Coordination of Members transitioning from LME/MCOs into the PHP;
    d. Coordination of Member transitioning from the Tribal Option into the PHP;

e. Coordination of Members transitioning from the PHP into Medicaid Fee-for-Service, LME/MCO or Tribal Option;
f. Coordination of Members transitioning from the PHP to another PHP; Coordination for Members in the Management of Inborn Errors of Metabolism (IEM) Program, as defined in the Standard Plan Contract at Section V.C.7. Prevention and Population Health Management Programs *of the Revised and Restated RFP 30-190029-DHB Request for Proposal;*
g. Coordination of services delivered under other sources of coverage, including Medicaid Fee-for-Service;
h. Notification to the Department of Members who have had two (2) or more visits to the emergency department for a psychiatric problem or two (2) or more episodes using behavioral health crisis services within the prior eighteen (18) months as defined in Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48;
i. Educating Members in a manner appropriate to Member's specific circumstance and capacity on the rights provided under this Policy and the processes for maintaining services during transitions of care;
j. Educating a transitioning Member's current provider network on changes to the provider enrollment and reimbursement processes; and
k. Other requirements as required in this Policy.

C. Additional Transition of Care Requirements for Care-Managed Members

1. The PHP's Transition of Care Policy shall integrate processes and procedures for managing the transition of a care-managed Member. Processes and procedures shall reflect the following expectations;
    a. Coordinate a timely Warm Handoff if deemed necessary for effective knowledge transfer or to ensure Member continuity of care;
    b. Promote proactive communication with the receiving entity prior to transition to coordinate the transfer of care;
    c. Establish a follow-up protocol to communicate with the receiving entity after the Member's transition to confirm receipt of the transferred information and to troubleshoot dynamics that may have resulted from the transition; and
    d. Recognize population-specific care management requirements as reflected in the Standard Plan contract (e.g. LTSS) and as outlined in the NC DHHS Transition of Care Policy

D. Additional Requirements for Members Disenrolling from PHP to NC Medicaid Direct (including LME/MCO) or Tribal Option

1. The PHP's Transition of Care Policy shall integrate process and procedures for supporting Members disenrolling to NC Medicaid Direct (including to an LME/MCO) or Tribal Option. The processes and procedures shall reflect the following requirements:

a. Adherence to population-specific Disenrollment Protocols established by the Department, which designate the population's appropriate receiving entity, provide additional population-specific guidance for ensuring continuity of care and for assisting the Member through the disenrollment process.
b. Proactive communication with the receiving entity and the Member, as necessary, to facilitate continuity of care. Communication includes but is not limited to:
    i. Coordinating a warm handoff with the receiving entity on timelines established in this Policy;
    ii. Post-disenrollment follow up with the receiving entity to confirm receipt of transition file and consult on transition-related issues.
c. Coordination with entities necessary to ensure Member continuity of care upon disenrollment, including but not limited to:
    i. Coordination with appropriate assessment entities, as applicable, to ensure no disruption in the Member's enrollment in a comparable Fee-for-Service service or program; and
    ii. Informing the Member's current Medicaid providers of the anticipated disenrollment.

E. Transition of Care Requirements with Change of Providers

1. The PHP shall develop policies, processes, and procedures to support Members transitioning between providers when a provider is terminated from the PHP's network.
2. In instances in which a provider leaves the PHP's network for expiration or nonrenewal of the contract and the Member is in Ongoing Course of Treatment *or* has an Ongoing Special Condition, the PHP shall permit the Member to continue seeing his/her provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).
3. In instances in which a provider leaves the PHP's network for reasons related to quality of care or program integrity, the PHP shall notify the Member in accordance with this Section and assist the Member in transitioning to an appropriate in network provider that can meet the Member's needs.
4. Member Notification of Provider Termination
    a. The PHP shall provide written notice of termination of a network provider to all Members who have received services from the terminated provider within the six months immediately preceding the date of notice of termination.42 C.F.R. § 438.10(f)(1).
    b. The PHP shall provide the written notice of termination of a network provider to Members within fifteen (15) calendar days of the provider termination, except if a terminated provider is an Advanced Medical

Home (AMH)/Primary Care Provider (PCP) for a Member. 42 C.F.R. § 438.10(f)(1).

c. If a terminated provider is an AMH/PCP for a Member, the PHP shall notify the Member within seven (7) calendar days of the following:
   (1) Procedures for selecting an alternative AMH/PCP.
   (2) That the Member will be assigned to an AMH/PCP if they do not actively select one within thirty (30) calendar days.
d. If a terminated provider is an AMH/PCP for a Member, the PHP shall validate that the Member selects or is assigned to a new AMH/PCP within thirty (30) calendar days of the date of notice to the Member and notifies the Member of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.
e. The PHP shall use a Member notice consistent with the Department-developed model Member notice for the notification required by this Section. 42 C.F.R. §438.10(c)(4)(ii).

5. The PHP shall hold the Member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.
6. The PHP shall establish a Provider Transition of Care Policy. The Provider Transition of Care Policy shall include processes and procedures for:
   a. Coordination of care for Members who have an Ongoing Special Condition;
   b. Coordination for Members discharged from a High Level Clinical Setting;
   c. Coordination for Members seeing a provider that leaves the PHP's network;
   d. Coordination for Members needing to select a new AMH/PCP after a provider termination; and
   e. Other requirements as defined in this Section.

F. Transitional Care Management.

1. The PHP shall develop policies and procedures for Transitional Care Management consistent with the requirements and protocols provided or referenced in this Policy.
2. The PHP shall manage transitions of care for Members transitioning between PHPs or between payment delivery systems. Care managers assisting Members through the transition or potential transition between PHPs or between payment delivery systems shall follow the requirements and protocols provided or referenced in this Policy.
3. The PHP shall also manage transitions of care (defined as Care Transitions) for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes.

4. The PHP shall develop a methodology for identifying Members who are at risk of readmissions and other poor outcomes. This methodology shall consider:
    a. Frequency, duration and acuity of inpatient, skilled nursing facility (SNF) and long-term service and supports (LTSS) admissions or emergency department (ED) visits;
    b. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
    c. Neonatal Intensive Care Unit (NICU) discharges; and
    d. Identification of patients by severity of condition, medications, risk score, healthy opportunities, and other factors the PHP may prioritize.

5. As part of Transitional Care Management provided to identified Members who are moving from one clinical setting to another, the PHP shall:
    a. Outreach to the Member's AMH/PCP and all other medical providers;
    b. Facilitate clinical handoffs;
    c. Obtain a copy of the discharge plan and verify that the care manager of the Member receives and reviews the discharge plan with the Member and the facility;
    d. Ensure that a follow up outpatient and/or home visit is scheduled within a clinically appropriate time window;
    e. Conduct medication management, including reconciliation, and support medication adherence though Member education;
    f. Ensure that a care manager is assigned to manage the transition;
    g. Ensure that the assigned care manager rapidly follows up with the Member following discharge; and
    h. Develop a protocol for determining the appropriate timing and format of such outreach.
    i. The PHP shall ensure that a comprehensive assessment is completed and current for all enrollees upon completion of Transitional Care Management, including re-assessment for enrollees already assigned to care management.
6. The PHP shall have access to an admission, discharge, and transfer (ADT) data source that correctly identifies when Members are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.
7. As part of Transitional Care Management, the PHP shall implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:

a. Real time (minutes/hours) response to notifications of emergency department visits, for example by contacting the ED to arrange rapid follow-up;
b. Same-day or next-day outreach for designated high-risk subsets of the population, such as children with special health care needs admitted to the hospital;
c. Additional outreach within several day days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or ED (e.g. to assist with scheduling appropriate follow up visits or medication reconciliations post discharge).

IV. Definitions and Clarification of Identified Terms

Care Transitions	The process of assisting a Member to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g. school-related transitions).
Crossover Population	North Carolina Medicaid and NC Health Choice beneficiaries who are enrolled in the Medicaid Fee-for-Service program and will transition to NC Medicaid Managed Care at a specific date established by the Department.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Medicaid's benefit for children and adolescents under age 21 in low-income families includes a broad selection of preventive, diagnostic and treatment services. Also known as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, its mandates and guarantees are listed in federal Medicaid law at 42 U.S.C. §1396a(a) (43) and 1396d(r) [1902(a) and 1905(a)(r) of the Social Security Act.
High Level Clinical Settings	○ Hospital/inpatient acute care and long-term acute care ○ Nursing facility ○ Adult care home ○ Inpatient behavioral health services ○ Facility-based crisis services for children and for adults. ○ Alcohol and drug abuse treatment centers (ADATCs)
Local Management Entity-Managed Care	Local Management Entities – Managed Care Organizations (LME/MCOs) are public managed care organizations that provide a comprehensive behavioral health services plan under the NC

Organization (LME/MCO)	1915(b)(c) Waiver for people in need of mental health, developmental disability, or substance use services. LME/MCOs are regionally based.[2]
North Carolina Medicaid Direct	The North Carolina Medicaid Program, excluding NC Medicaid Managed Care. NC Medicaid Direct includes services covered through NC Medicaid's fee-for-service program; services covered by NC Local Management Entities/Managed Care Organizations (LME/MCOs) and Program for All-Inclusive Care for the Elderly (PACE).
Ongoing Course of Treatment	When a Member, in the absence of continued services, reflected in a treatment or service plan or as otherwise clinically indicated, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
Ongoing Special Condition	AS defined in N.C. Gen. Stat. §58-67-88
Disenrollment Protocols	Protocols developed by the Department to be followed by the PHP when assisting designated disenrolling populations through the transition process back to NC Medicaid Direct. Protocols identify the receiving entity for each population and provide interventions to help ensure continuity of care. The Department will establish protocols to assist Members who are disenrolling due to Medicare eligibility, Foster Care enrollment, Tailored Plan eligibility and disenrollment into NC Medicaid Direct LTSS Program. The Department reserves the right to develop additional protocols as necessary to meet the service continuity needs of disenrolling Members.
Receiving Entity	The entity that is enrolling the transitioning Member and receiving the Member's information.
Transferring Entity	The entity that is disenrolling the transitioning Member and transferring the Member's information.
Transition of Care	The process of assisting a Member to transition between PHPs or between payment delivery systems including transitions that result in the disenrollment from managed care. Transitions of care also include the process of assisting a Member to transition between providers upon a provider's termination from the PHP network. The Department identifies two categories of Transition of Care: **Transition of Care, Crossover:** The timeframe immediately before and after the implementation date of the North Carolina Medicaid Managed Care model in the applicable region. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the crossover population during this

[2] An LME/MCO directory can be found at: https://www.ncdhhs.gov/providers/lme-mco-directory

	time of transition. Crossover-specific requirements are provided in Attachment A.; **Transition of Care, Ongoing:** The process of assisting a Member to transition between PHPs or to other payment delivery systems, including transitions that result in the disenrollment from managed care. Transitions of care also includes the process of assisting a Member to transition between providers upon a provider's termination from the PHP provider network.
Transitional Care Management	Management of Member needs during Transitions of Care and Care Transitions (e.g. from hospital to home).
Warm Handoff	Time-sensitive, Member-specific planning for Members identified by either the transferring or receiving entity but minimally include: 1) transitioning care managed Members for whom the PHP deems a warm handoff necessary to ensure continuity of care; 2) Members disenrolling due to Medicare eligibility, foster care eligibility, facility admission that results in disenrollment and Members disenrolling due to LME/MCO service eligibility. "Warm Handoffs" require collaborative transition planning between both transferring and receiving entities and as possible, occur prior to the transition.

Compliance and Monitoring

The Department shall monitor PHP Transition of Care activity through reporting requirements as specified in Standard Plan contract at Attachment J of the *Revised and Restated RFP 30-190029-DHB Request for Proposal* and through additional methods determined by the Department.

Relevant Regulatory and Legislation Citations

42 C.F.R. § 438.10

42 C.F.R § 438.62

42 C.F.R §438.208

N.C. Gen. Stat. § 58-67-88

S.L. 2018-48 (H 403)

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APPENDIX A: Transition of Care at Crossover

Member transitions between service delivery systems are collectively referred to as Transition of Care (TOC). The Department has recognized that Transition of Care involves two distinct phases:

1. Crossover
2. Ongoing Transition of Care

As beneficiaries move between delivery systems, the Department's expectation is processes will be in place that ensure continuity of care for each Member and minimize the burden on providers during the transition. Recognizing the specific dynamics and needs during the Crossover phase, the Department has established time-limited requirements of the PHPs in this Appendix A of the NC DHHS Transition of Care Policy.

Crossover: Applicable Definitions

Crossover: The timeframe immediately before and after the implementation date of the North Carolina Medicaid Managed Care model in the applicable region. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the crossover population during this time of transition.

Crossover Timeframe: The timeframe immediately before and after the implementation date of Medicaid Managed Care. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the Crossover Population during this time of transition.

Episode of Care: A treatment or intervention covered under the Standard Plan benefit, initiated prior to MCL and evidenced by a current treatment plan, that is related to a Member's condition or circumstance and is provided to the Member by the nonparticipating provider within the first 60 days after MCL.

High-Need Member: Beneficiaries requiring time-sensitive, Member-specific follow up by the PHPs during Crossover. High Need Members include but are not limited to Members with open or recently closed PAs in the following services:

- High Need subset of Members receiving long-term services and supports.
    - Members receiving or authorized to receive PDN services who have also experienced on or more ED visits or hospitalizations within 30 days of MCL.
    - Members receiving or authorized to receive Home Health services who have also experienced one or more ED visits or hospitalizations within 30 days of MCL.
    - Members who have received HIT services, with DOS within 30 days of MCL.
    - Members who have been enrolled in a Nursing Facility for 30 calendar days or less at MCL. Members authorized for 80 or more hours a month of Personal Care Services or minors utilizing Personal Care Services.
- Members receiving crisis behavioral health services within six months of MCL;
- Members with Inborn Errors of Metabolism;
- Members identified by CCNC, an LME/MCO or the Department who have complex treatment circumstances or multiple service interventions and necessitate a Warm Handoff;
- Members who are experiencing a care transition from a High Level Clinical Setting;
- Identified Standard Plan exempt Members who elected to enroll in Standard Plan;
- Members authorized for transplantation;
- Members authorized for out of state services; and
- Other high need Member or group of Members identified by the Department or the PHP.

Managed Care Launch (MCL) The date on which the NC Medicaid program converts from a fee-for-service delivery model to a managed care delivery model for enrolled beneficiaries. This date is also referred to as *Implementation*.

Warm Handoff: Member-specific meeting/knowledge transfer session between transferring entity and PHP. Members requiring a "Warm Handoff" at Crossover may be identified by either the Member's PHP or applicable Medicaid Direct "transferring entity," but the Department anticipates the transferring Medicaid Direct entity will be better positioned to determine if a Member's specific circumstance requires a formal warm handoff briefing.

Follow Up: Direct contact with the identified Member/authorized representative to confirm continuity of services; to provide any Member-specific PHP contact information directly to Member/authorized representative; to address any Crossover-related issues the Member may be experiencing. PHPs shall prioritize follow up activity with High Need Members based on

urgency of need but should strive to conduct follow up with identified High Need Members no later than three weeks following MCL.

Key Services: Key services are defined by the Member, the PHP and/or care plan, but shall minimally include NEMT maintained without disruption, LTSS in-home service supports have continued without disruption, medications have been refilled as scheduled, behavioral supports have continued without disruption.

Crossover Requirements: Data Transfer and PHP Acceptance of Data Files

Requirements

- PHPs have the capacity to accept, ingest and utilize claims, encounter, pharmacy lock-in files and prior authorization data files identified in the *Transition of Care: Technical Implementation Overview and Schedule* and subsequent guidance.
- PHPs have the capacity to accept, ingest and utilize service assessment and care plan detail available to the PHP.
- PHPs participate in the Department's strategy to minimize service disruption at Crossover due to erroneously submitted Prior Authorizations. Participation includes but is not limited to:
    - Providing information about the PHP's prior authorization process to be included in the Department-sponsored PHP PA Resource webpage.
    - Establishing the functionality necessary to accept "warm transfer" calls from Utilization Management Vendors receive a call-in PA request.
    - Provide related data as identified in the *Crossover Requirements: Reporting* section of this Appendix.
    - Participate in provider education efforts as provided in the *Crossover Requirements: Provider Education* section of this Appendix.

Crossover Requirements: Management of High Need Member Supports and Services

Requirements

- PHPs participate in Member-specific knowledge transfer sessions known as Warm Handoffs for Members identified by either transferring entity or by the PHP. Warm Handoffs will begin three weeks prior to MCL and be completed no later than one week after launch.

- PHPs provide expedited follow up after MCL with High Need Members as defined within this Appendix to:
    - Ensure identified services have continued without disruption;

- Initiate post MCL assessments that may be required to evaluate the Member's continuation of services after 90 days;
- Ensure uninterrupted access to NEMT.

❖ PHPs provide High Need Member-level updates to the Department in a manner identified by the Department and as outlined in Reporting section of the Department's Transition of Care Policy.

Crossover Requirements: Non-Emergency Medical Transit (NEMT) Management

Requirements

❖ PHPs begin accepting requests for NEMT scheduling for post MCL appointments from enrolled Members no later than one month prior to MCL.

Crossover Requirements: Honoring Existing and Active Fee-For-Services Prior Authorizations for 90 Days Post MCL

Requirements

❖ To ensure continuity of care Members, the PHP must honor existing and active medical prior authorizations (PAs) on file with the North Carolina Medicaid or NC Health Choice program for minimally the first ninety (90) days after implementation or until the expiration/completion of a PA, whichever occurs first. For service authorizations managed by an LME/MCO and under the scope of 42 CFR Part 2 , the PHP shall deem authorizations submitted directly by impacted providers as covered under this requirement.

❖ Fee-for-service (FFS) Utilization Management Vendors and Behavioral Health Local Management Entities-Managed Care Organizations (LME/MCOs) will continue to receive PA requests up to 11:59 pre-MCL and process those requests per their standard processes and SLAs, even if processing continues beyond MCL. Accordingly, the PHP may receive additional FFS PAs on the incremental PA transfer file after MCL. The PHP shall honor these FFS PAs for the first 90 days after MCL, following the related requirements and protocols established for FFS PAs.

❖ For new Prior Authorization requests submitted by providers to the PHP on or after MCL, standard utilization management requirements and allowances as specified in the PHP contracts apply. New Prior Authorization requests submitted by providers to the PHP may include requests for reauthorization of services initially authorized in FFS.

- PHPs are strongly advised to consider the Member's prior service history, and prior clinical circumstance when reviewing new PA requests, including reauthorization requests, during the Crossover time period.

Crossover Requirements: PHP Payment of Services in Place at Crossover

Requirements

- Generally, PHPs assume responsibility for services with dates of service on or after the applicable MCL date.

- For the first sixty (60) days after MCL, PHPs are required to pay claims and authorize services for Medicaid eligible nonparticipating/out-of-network providers equal to that of in-network providers until the end of Episode of Care or the 60 days, whichever is less. [3]Unless the Member has an Ongoing Special Condition or is under an Ongoing Course of Treatment. In these circumstances, the PHP shall follow the timeframes provided in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).

- For Medicaid beneficiaries who are admitted to an acute care facility and eligible for full Medicaid fee-for-service coverage prior to MCL and discharged after MCL, the Medicaid fee-for-service program will pay DRG-associated claims.

Crossover Requirements: Additional Prior Authorization Dynamics

Requirements

- **Unmanaged Visits for Outpatient Behavioral Health Services**
  Per the Standard- Plan contract, PHPs are required to adhere to Department's Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-enrolled Providers.* This policy states in relevant part: *Outpatient behavioral health services coverage is limited to eight unmanaged outpatient visits for adults and 16 unmanaged outpatient visits for children per state fiscal year (inclusive of assessment and Psychological Testing codes)*. **For Members who are authorized for services under this Clinical Coverage Policy at Managed Care Launch (MCL), the unmanaged visit count shall reset to zero**. PHPs are otherwise required to adhere to Clinical Coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers.*

[3] See Standard Plan contract at Revised and Restated RFP 30-190029-DHB Request for Proposal Section V. Scope of Services Page 88 of 214

Crossover Requirements: PHP Governance Processes

Requirements

- The PHP's Transition of Care Policy shall reflect how the PHP will monitor the implementation and ongoing activity related to the requirements identified in this Appendix.
- The PHP shall participate in state-sponsored Crossover-specific monitoring activities including but not limited to:
    - Time-limited Crossover "stand up" meetings with NC Medicaid staff and vendors on a schedule to be determined by the Department.
    - Time-limited, rapid cycle solutioning process related to data transfer issues and Member disruption in care.
    - Complete and submit Crossover status reports and data reconciliation detail as outlined in the *Crossover Requirements: Reporting* section of this Policy Appendix.

Crossover Requirements: Reporting

Requirements

- The PHP shall participate in file transfer, data reconciliation processes and reporting as identified by the Department.

- The PHP shall provide status reports on engagement activities and service disposition of High Need Members.

- The PHP will track and has the capacity to report and reconcile Member-specific data related to:
    - NEMT appointments received during Crossover time period;
    - Open appeals at MCL;
    - Post-MCL PA unit utilization.

Crossover Requirements: Member and Provider Education

The Department will not require formal call center scripts for Crossover-specific dynamics. The Department will establish Crossover -specific "talking points" that the PHP will incorporate into its Call Center protocols and staff training, providing additional training to the PHPs as needed. The Department will finalize these talking points and require the PHP to attest to the training

and integration of these statements into its Call Center protocols at a later date, determined by the Department.
Crossover-related Call Center content will include:

- Guidance to providers about identifying Member's plan enrollment status;
- Guidance to providers on Crossover-related PA submission requirements;
- Guidance to providers on applicable continuity of care provisions in the Standard Plan contract and subsequent policy statements.
- Guidance to Members on pre-MCL scheduling of post MCL NEMT appointments;
- Additional guidance as necessary to ensure Member continuity of care and provider clarity on applicable Crossover processes.

Crossover Requirements: Crossover-Specific Considerations for Adverse Determination and Appeals

- Generally, PHP activity is governed by *Member Grievances and Appeals* section of Revised and Restated RFP.[4]
- The PHP and the Department shall follow any resulting order by Office of Administrative Hearings (OAH) or another court.

Appeals-Related Considerations at Crossover
Requirement: Pre-MCL Prior Authorization (PA) Processing Utilization Management Vendors *(or state staff, as applicable)* will continue to receive Prior Authorization (PA) requests up to 11:59 pre-Managed Care Launch ("MCL" or "Implementation") and process those requests per their standard processes and service-level agreements (SLAs). • If the Prior Authorization review process extends beyond MCL and is authorized, the PHP shall honor for the duration of the authorization or 90 days after MCL, whichever occurs first. • If the Prior Authorization review process extends beyond MCL, is not authorized and this adverse determination results in an appeal, the Department will seek to dismiss the appeal on the grounds identified in this Appendix.
Requirement: Maintenance of Service (MOS) If fee-for-service Maintenance of Service (MOS) is in effect for a Member at MCL, for a service covered by the PHP, the PHP is financially responsible for post MCL services provided under MOS until the PHP reassesses and either approves the service or issues its own adverse decision with appeal rights.

[4] Revised and Restated RFP 30-190029-DHB Request for Proposal Section V. Scope of Services Page 35 of 214

Position Statement: The Disposition of MOS/COB (Continuation of Benefits) for LME/MCO-Sponsored Services for Member who Transfers to the PHP (NEW)

- If MOS/COB is for service *not* covered by PHP and Member has voluntarily, proactively transferred from LME/MCO to PHP (Standard Plan Exempt), Member has waived MOS upon transfer.
- If MOS/COB is for service that IS covered by PHP, MOS protocol outlined in MOS Requirement applies.

Position Statement: Retroactive PA Requests

If a provider submits a *retroactive* PA covering both a fee-for-service and PHP timespan, the UM entity receiving the retroactive PA request may review only the portion of the request covering the timespan under its authority.

Requirement: Related to *Position Statement, Retroactive PA Requests*

- The receiving entity must inform the provider of its inability to process the portion of the request that is out of the receiving entity's authority
- The provider will need to submit the remaining units to the appropriate authorizing entity.
- If the receiving entity reviews and denies the portion of the request within its authority, it must also issue appeal rights.

Requirement: PHP honoring fee-for-service PAs after MCL

The PHP must honor open fee-for-service PAs for first 90 days after MCL or to the date the PA expires or is concluded, if sooner than 90th day after MCL/ Implementation date.

Requirement: Appeal Rights on Terminated or Reduced pre-MCL Authorized Services.

If a PHP terminates/reduces a fee-for-service-authorized service after the 90 days, PHP must issue appeal rights. A PHP reassessment that potentially results in termination or reduction in services should begin sufficiently in advance of the 90th day, to remain in compliance with requirements specified in Member Grievances and Appeals section of Revised and Restated RFP.

- Related Reporting Requirement: PHP adverse determination on a fee-for-service-authorized service should be uploaded into the Medicaid Appeals and Grievance Clearinghouse.

APPENDIX B
Transition of Care: Special Considerations for Supporting Members Who May Meet Tailored Plan Criteria

Overview

This Appendix establishes the Department's requirements of Standard Plan PHPs to assist transitioning Members who are eligible for Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans or, prior to BH I/DD Tailored Plan launch, for LME/MCO enrollment.

Specifically, this Appendix includes requirements related to supporting:

1. Standard Plan Members who are not required to enroll in the Standard Plan because of BH I/DD Tailored Plan eligibility, but elect to do so; and
2. Standard Plan Members who may become BH I/DD Tailored Plan-eligible following their enrollment in Standard Plans.

The statements included in this Appendix are aligned with the Department's intended design outlined in:

1. Medicaid Managed Care Final Policy Guidance Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment ("Final Policy Guidance") and related updates;
2. The Department's report to the NC General Assembly's Joint Legislative Oversight Committee, Plan for Implementation of Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans, ("Plan for Implementation"); and
3. In accordance with related legislation.

Definitions

Behavioral Health/Intellectual Developmental Disability Tailored Plan (BH I/DD Tailored Plan):

Behavioral Health I/DD Tailored Plans are specialized managed care products targeting the needs of individuals with significant behavioral health disorders, intellectual and developmental disabilities (I/DD), and traumatic brain injuries (TBI). These plans are scheduled to begin in July 2022. Prior to launch, beneficiaries meeting eligibility for the Behavioral Health I/DD Tailored Plans will continue to be covered through the current Medicaid fee-for-service/local management entity – managed care organization (LME/MCO) system, also referenced as NC Medicaid Direct.[5]

[5] https://files.nc.gov/ncdhhs/medicaid/BH-IDD-TP-Eligibility-Enrollment-Update-FINAL-20190716.pdf

BH I/DD Tailored Plan eligible/ Meeting "Tailored Plan Criteria:" Beneficiaries who are eligible and auto-enrolled in a BH I/DD Tailored Plan (or Medicaid Direct/LME/MCOs prior to BH I/DD Tailored Plan launch) and meet the criteria provided in *North Carolina Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment APPENDIX B, BH I/DD TAILORED PLAN CRITERIA, updated August 2, 2019 and again on February 2, 2021*.[6]

Beneficiaries who are not initially identified as Tailored Plan eligible will be able to request a review to determine whether they are eligible to enroll in a BH I/DD Tailored Plan. [7]

Tailored Plan Eligibility Request Process: The process established to support Standard Plan enrolled Members wishing to request transfer into the BH/IDD Tailored Plan or preceding the launch of Tailored Plan, for Medicaid Direct due to the need for services provided by the LME/MCO.[8]

Overarching Expectation of Support for PHP Members Who May Meet Tailored Plan Criteria

A Standard Plan shall effectively provide behavioral health supports to its Members, which includes ensuring that its Members have access to clinically indicated behavioral health services within the Standard Plan's scope. If a Member requires services or interventions available only through the BH I/DD Tailored Plan or LME/MCO prior to BH I/DD Tailored Plan Launch, the Standard Plan shall support the Member to understand the service options available and assist the Member through any subsequent transition to the BH I/DD Tailored Plan or LME/MCO.

Special Transition of Care Considerations for Members Who May Meet Tailored Plan Criteria

DHHS Policy Positions and Requirements

- Medicaid beneficiaries identified as eligible for the BH I/DD Tailored Plans default to LME/MCO enrollment until BH I/DD Tailored Plans launch but will have the option to

[6] https://files.nc.gov/ncdhhs/medicaid/BH-IDD-TP-EligibilityUpdate-AppendixB-REVFINAL-20190802.pdf
https://files.nc.gov/ncdhhs/BH-IDD-TP-Eligibility-Enrollment-Update-02.02.2021.pdf

[7] https://files.nc.gov/ncdhhs/medicaid/BH-IDD-TP-EligibilityUpdate-AppendixB-REVFINAL-20190802.pdf
This list includes both those Members whose enrollment may default to LME/MCO or Tailored Plan but may elect to enroll in the Standard Plan and those Members who may be later identified as Tailored Plan-Eligible. For additional clarification, please review the *Final Policy Guidance*.

[8] Additional description can be found at: https://files.nc.gov/ncdhhs/medicaid/BH-IDD-TP-Eligibility-Enrollment-Update-FINAL-20190716.pdf

enroll in a Standard Plan PHP.[9] Members who are eligible for the BH I/DD Tailored Plan but have chosen to enroll in a Standard Plan will be identifiable on the 834 Eligibility File. BH/IDD Tailored Plan eligible Members who remain in or return to the Standard Plan shall be designated by the PHP as a Priority Population for Care Management under the *Adults and Children with Special Healthcare Needs* category.

- To ensure access to necessary services, the Department has established the following pathways for identifying Standard Plan Members who may be more appropriately served under the BH/IDD Tailored Plan (or by LME/MCO prior to Tailored Plan Launch):
    - Members identified through the Department Claim and Encounter Review;
    - Members identified through the BH I/DD Tailored Plan Eligibility Request process;
    - Members who experience other qualifying events, as reflected in the Tailored Plan Eligible definition within this Appendix.

- The Standard Plan shall follow protocols set by the Department related to identifying, reporting and assisting applicable Standard Plan Members who may be more appropriately served under the BH I/DD Tailored Plans (or only by NC Medicaid Direct/LME/MCOs prior to the BH I/DD Tailored Plan launch).

- To assist Members who may be eligible for the BH I/DD Tailored Plans, the Standard Plan shall train care managers in services available only through BH I/DD Tailored Plans, BH I/DD Tailored Plan eligibility criteria, and the process for an enrollee who needs a service that is available only through BH I/DD Tailored Plans to transfer to a BH I/DD Tailored Plan.

- The Standard Plan shall establish internal policies and procedures for assisting Members who may be eligible for BH I/DD Tailored Plans and supporting those who elect to transfer during the transition to BH I/DD Tailored Plans or to LME/MCOs prior to the BH/IDD Tailored Plan launch. At a minimum, these policies and procedures shall be aligned with Standard Plan's overarching Transition of Care policy, its procedures specific to disenrollment and transitioning care managed populations and shall also establish:
    - Internal operational processes for coordinating with providers on the submission of a Transition Request form as defined in this Policy Appendix's definitions.
    - Internal operational processes for coordinating with Department on supporting the transition of Members identified for disenrollment due to Tailored Plan eligibility.

[9] *Medicaid Managed Care Final Policy Guidance Behavioral Health and Intellectual/Developmental Disability Tailored Plan Eligibility and Enrollment,* pg. 6. Medicaid beneficiaries enrolled in the Innovations and Traumatic Brain Injury (TBI) waivers will be required to disenroll from their waivers prior to enrolling in Standard Plans.

- Follow up protocols for newly enrolled Members consistent with those provided in *Additional Transition of Care Requirements for Care Managed Members* section of the NC DHHS Transition of Care Policy.

❖ Standard Plans are required to provide NC Medicaid State Plan behavioral health or I/DD services subject to EPSDT that are typically offered only by Behavioral Health I/DD Tailored Plans to children under age 21 who require a service. EPSDT does not cover habilitative services, respite services, or other services approved by CMS that can help prevent institutionalization. Those services will only be available in the Behavioral Health I/DD Tailored Plans.

- If a Medicaid enrolled child is enrolled in a Standard Plan PHP and needs a service that is covered in the BH I/DD Tailored Plans service array (but not Standard Plans), and the service meets the requirements for EPSDT, the Standard Plan PHP must cover that service for any period the beneficiary is enrolled with that PHP. When the encounter for that service comes to the Department, the Department will flag the beneficiary as Tailored Plan eligible and he/she will be disenrolled from the PHP and moved into Medicaid Direct (until Tailored Plans go live), in accordance with the Auto Enrollment of Tailored Plan -Eligible Members.

❖ The Standard Plan shall report on activities related to identifying, reporting, and assisting BH I/DD Tailored Plan-eligible Members, in a manner specified by the Department.

❖ For all Members referenced in this Appendix who transition to an LME/MCO or a BH I/DD Tailored Plan, Transition of Care requirements, as specified in the Standard Plan Contract at *Revised and Restated RFP 30-190029-DHB Request for Proposal, Section V.C.4* and the NC DHHS Transition of Care Policy apply. All applicable requirements will be reflected in the Department's Transition of Care Policy.