TennCare Policy Manual

Policy No:	CON 19-001
Subject:	Addressing the Care Needs of Enrollees Transitioning from One MCO to Another MCO
Approval:	**Date:** 3/7/19

BACKGROUND:

In 2016, the Centers for Medicare and Medicaid Services (CMS) published an update to the managed care regulations governing Medicaid and the Children's Health Insurance Program (CHIP).[1] One requirement of the 2016 update is that each state's Medicaid program must have in effect a transition of care policy that addresses the care needs of enrollees transitioning from a fee-for-service delivery system to a managed care service delivery system, or from one managed care entity to another. In Tennessee, all TennCare members are enrolled in managed care, meaning that there are no instances in which an enrollee transitions from fee-for-service arrangements to managed care.

CMS's 2016 rule identifies five elements that must be included in each state's transition of care policy:

A. Transferring members must have access to services consistent with the access previously held and may retain their current providers temporarily if the providers are not in the network to which the member is transferring.
B. Transferring members are referred to appropriate network providers.
C. Requests from the member's new managed care entity for historical utilization data are timely fulfilled.
D. The member's new providers are able to obtain copies of the member's medical records.
E. Medicaid programs should adopt any other procedures necessary to ensure continued access to covered services for transferring members.[2]

The manner in which TennCare addresses each of these five elements is detailed below in the section entitled "Procedures."

POLICY:

When a TennCare member transitions care from one managed care organization (MCO) to another, it is important that ongoing services be continued in an effort to maintain the health and well-being of the member. Steps taken by MCOs to ensure access to services and to appropriately transfer medical information facilitate a smooth transition of care, thereby promoting the health of the TennCare

[1] The 2016 update to the managed care regulations is available online at https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] See 42 CFR § 438.62(b)(1).

member. This policy describes the processes and protocols used by the MCOs to assure continuity of care for a TennCare member when transferring from one MCO to another.[3]

PROCEDURES:[4]

A. Access to Consistent Services

TennCare members transferring from one MCO to another are entitled to access to services consistent with the access they previously had and are permitted to retain their current providers for a period of time if those providers are not in the new MCO's network. The following procedures explain how long MCOs must provide continuation of services with existing providers before TennCare members may be referred to providers within the new MCO's network.

1) Covered Services Other Than Long-Term Services and Supports (LTSS): For medically necessary covered services (other than LTSS) being delivered by a provider outside the MCO's network, the MCO receiving a transferring member will provide continuation of such services for up to 90 calendar days or until the member may be reasonably transferred without disruption to a contract provider, whichever is less. The MCO may require prior authorization for continuation of services beyond 30 calendar days; however, the MCO may not deny authorization solely on the basis that the provider is outside the MCO's network.

2) Prenatal Services: If a TennCare member is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before the transfer, the MCO receiving the transfer will be responsible for the costs of continuation of medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without any form of prior approval and without regard to whether such services are being provided by an MCO contract provider or a provider outside the MCO's network.

   If a TennCare member is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before the transfer, the MCO receiving the transfer will be responsible for providing continued access to the prenatal care provider (regardless of whether the provider is in the receiving MCO's network) through the postpartum period, without any form of prior approval.

3) Long-Term Services and Supports: For covered LTSS for individuals enrolled in CHOICES (TennCare's LTSS program for individuals who are elderly or disabled) or ECF CHOICES (TennCare's managed LTSS program for individuals with intellectual and developmental disabilities) who are transferring from another MCO, the MCO receiving the transfer will be responsible for continuing to provide covered LTSS, including both CHOICES and ECF CHOICES

[3] CMS's 2016 update to the managed care regulations specifies that a state's transition of care policy must address transfers between MCOs, prepaid ambulatory health plans (PAHPs), prepaid inpatient health plans (PIHPs), primary care case managers (PCCMs), and primary care case management entities (PCCM entities). TennCare does not have contracts with PCCMs or PCCM entities, and the two PAHPs with which TennCare contracts provide different services (dental benefits management and pharmacy benefits management). Therefore, this policy is applicable only when a member transitions from one TennCare MCO to another, or when a member transitions between a TennCare MCO and TennCare's sole PIHP (TennCare Select).

[4] Much of the content in this section is addressed at greater length in section A.2. of the Contractor Risk Agreement: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.

home and community based services (HCBS) authorized by the transferring MCO and nursing facility services, without regard to whether such services are being provided by a provider in the receiving MCO's network.

B. Referral to Appropriate Providers In Network

TennCare members transferring from one MCO to another will receive referrals to appropriate providers within their new MCO network as outlined below.

1) Covered Services Other Than LTSS: The information contained in section A.1. of this policy is applicable in this instance as well.

2) Prenatal Services: If a transferring member is receiving services from a provider outside the network of the MCO receiving the transfer, that MCO will be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the MCO can reasonably transfer the member to a contract provider without impeding service delivery.

3) Long Term Services and Supports: For covered LTSS for CHOICES and ECF CHOICES members who transfer from another MCO, the MCO receiving the member will be responsible for continuing to provide covered LTSS without regard to whether such services are being provided by a provider in the receiving MCO's network. Procedures related to CHOICES and ECF CHOICES (discussed at greater length in the Contractor Risk Agreement) are as follows:

- CHOICES Group 1: For a transferring member in CHOICES Group 1, a Care Coordinator will conduct a face-to-face in-facility visit within 30 days of the member's enrollment in the new MCO and will conduct a comprehensive assessment as determined necessary by the MCO. Nursing facility services should be provided to the member in accordance with reimbursement approved by TennCare; however, the member may be transitioned to the community according to the procedures outlined in the Contractor Risk Agreement.

- CHOICES Group 2 or 3 or ECF CHOICES: The receiving MCO will continue CHOICES or ECF CHOICES HCBS for a minimum of 30 days and thereafter may not reduce these services unless a comprehensive needs assessment has been conducted, a plan of care or person-centered support plan (PCSP) has been developed, and the MCO has authorized and initiated CHOICES or ECF CHOICES HCBS in accordance with the member's new plan of care or PCSP.

  If a member in CHOICES Group 2 or 3 or ECF CHOICES is receiving short-term nursing facility care when a transition to a new MCO occurs, the receiving MCO must continue to provide nursing facility services to the member in accordance with the level of nursing facility services and/or reimbursement approved by TennCare. The MCO must also complete a face-to-face visit prior to the expiration date of the level of nursing facility services approved by TennCare, but no later than 30 days after enrollment, to determine appropriate comprehensive assessment and care planning. If the expiration date for the level of nursing facility services approved by TennCare occurs prior to 30 days after enrollment, and the MCO receiving the transfer is unable to conduct the face-to-face visit prior to the expiration date, the MCO receiving the transfer will be responsible for facilitating discharge to the

community or enrollment in CHOICES Group 1, whichever is appropriate, prior to the member's exhaustion of the 90-day short-term nursing facility benefit.

If at any time before conducting a comprehensive assessment for a transitioning member in CHOICES Groups 2 or 3 the MCO becomes aware of an increase in the member's needs, the member's Care Coordinator should immediately conduct a comprehensive assessment and update the member's PCSP, and the MCO should initiate the change in services within ten days of becoming aware of the change in the member's needs.

C. Historical Utilization Data

TennCare ensures that appropriate actions are taken to facilitate the exchange of historical utilization data when a member transfers from one MCO to another. Upon notification of a member transfer, the receiving MCO will immediately contact the member's previous MCO and request transition of care data. Conversely, if an MCO is contacted by another MCO requesting the transition of care data for a member who has transferred, the original MCO must provide that data as soon as possible or by the receiving MCO's requested deadline.

In addition, TennCare has instituted procedures, via a "Red Flag" trigger[5], to make sure that data for a member with an urgent or complex medical need is safely, securely, and efficiently transferred to prevent any detriment to the member's health. These procedures set forth the responsibilities and timeframes for the sending and receiving MCOs in facilitating the transition of care data, which includes open authorization data and historical encounter data (both paid and denied claims for the previous 12 months). To assure that MCOs are in compliance with the procedures, staff is educated about the "Red Flag" triggers and their associated transition of care process, and adherence is tracked and monitored by TennCare.

D. Access to Medical Records

TennCare institutes measures to make sure medical records are appropriately maintained and can be transferred from one MCO to another when a member transfers MCOs. As outlined in the MCOs' Contractor Risk Agreement, each MCO must have medical record-keeping policies and practices which are consistent with 42 CFR Part 456[6] and current National Committee for Quality Assurance (NCQA) standards for medical record documentation.[7] At a minimum, the policies and procedures should address confidentiality of medical records, medical record documentation standards, and the medical record-keeping system and standards for the availability of medical records.[8]

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[5] A "Red Flag" trigger occurs when 1) a TennCare member has a complicated social, behavioral, or medical situation that requires at least weekly interventions; 2) the Department of Children's Services or the Department of Adult Protective Services population is referred to or involved with a TennCare member who has a highly complex medical condition requiring at least weekly interventions; or 3) there is any other member-related situation in which intervention is urgent and the situation requires contact on a daily to weekly basis.

[6] See https://ecfr.io/Title-42/cfr456_main.

[7] See NCQA Guidelines for Medical Record Documentation: https://www.ncqa.org/wp-content/uploads/2018/07/20180110_Guidelines_Medical_Record_Documentation.pdf.

[8] See Section A.2.24.8.2 Contractor Risk Agreement: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.

In addition, in the event a member changes primary care providers, such as when a member transfers to a new MCO, medical records must be sent from the former provider to the new provider without a fee to either the new provider or the member. Tennessee Code stipulates that a provider must submit to the member, or member's authorized representative, a copy or summary of the patient's medical records within ten (10) working days upon request in writing by the member or their representative.[9]

E. Other Procedures to Ensure Continued Access to Covered Services

TennCare works closely with its MCOs to ensure that members receive continued access to covered services when transferring MCOs. The transfer of membership from one MCO to another can occur at any time during the year with no waiting period. In addition, TennCare requires that each operating MCO must meet network adequacy standards to assure that there are enough providers in every member's geographical region to meet his or her needs. These measures guarantee that a transferred member will receive access to ongoing care by the appropriate providers. For members who have an urgent and/or complex medical need, a protocol as outlined in section C, above, is adhered to by the MCOs and is routinely monitored by TennCare to assure compliance.

PUBLIC ACCESS TO TRANSITION OF CARE POLICIES:

Consistent with CMS' Managed Care Rule, it is the policy of TennCare that each MCO maintain procedures regarding the transition of members from one MCO to another.[10] Furthermore, each MCO's transition of care policy must be publicly available in their member handbook.[11]

OFFICES OF PRIMARY RESPONSIBILITY:

Office of Managed Care Operations
Division of Quality Improvement

REFERENCES:

42 CFR 438.62 Continued services to recipients.
https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartB_section438.62#title42_chapterIV_part438_subpartB_section438.62

42 CFR 456 Utilization control.
https://ecfr.io/Title-42/cfr456_main

TCA § 63-2-101 Release of medical records.
https://law.justia.com/codes/tennessee/2010/title-63/chapter-2/63-2-101/

[9] T.C.A. § 63-2-101
[10] See Section A.2.9.2.7 Contractor Risk Agreement: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.
[11] See Section A.2.17.4.6.27 Contractor Risk Agreement: https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.

Contractor Risk Agreement, Statewide Contract with Amendment 9 – January 1, 2019.
https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf

NCQA Guidelines for Medical Record Documentation.
https://www.ncqa.org/wp-content/uploads/2018/07/20180110_Guidelines_Medical_Record_Documentation.pdf

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