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Division of Medicaid and Medical Assistance

POLICY

See Also: Member Transfer Continuity of Care Form-2017_110617

Approved by: Dr Krishna Upadhya, MD

DMMA POL- TRANSITION OF CARE

Introduction

The mission of the State of Delaware (Delaware or State) Division of Medicaid & Medical Assistance (DMMA) is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost-effective manner. DMMA contracts with Managed Care Organizations (MCOs) to deliver care to DMMA Medicaid members.

Background

The Centers for Medicare & Medicaid Services (CMS) publishes managed care regulations governing Medicaid and the Children's Health Insurance Program. The transition of care (TOC) policy shall include, at a minimum, the requirements that are required within 42 CFR § 438.62(b)(1) and § 438.16(e)(2)(iv). The Contractor transition of new and existing enrollees shall minimize disruption to enrollees' established relationships with providers and existing care treatment plan and ensure medically necessary covered services are provided in a timely manner.

CMS regulations at identify five elements that must be included in each state's transition of care policy:

1. 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.

2. Transferring members are referred to appropriate network providers.

3. Requests from the members' new managed care entity for historical utilization data are fully and timely completed.

4. The member's new providers are able to obtain copies of the member's medical records, as appropriate.

5. Medicaid programs should adopt any other procedures necessary to ensure continued access to covered services for transferring members.

Regulations at 42 CFR 438.16(e) identifies the following element that must be included in each state's transition of care policy when an ILOS is terminated. ILOS are cost-effective substitute services that MCOs may voluntarily provide to members as long as DMMA approves the coverage:

6. A transition of care policy, not to exceed 12 months, to arrange for State plan services and settings to be provided timely and with minimal disruption to care to any enrollee who is currently receiving the ILOS that will be terminated. The State must make the transition of care policy publicly available.

Policy

When a DMMA member transitions care from FFS, from one MCO to another, or when an ILOS is terminated, it is important that ongoing services be continued in an effort to maintain the health and well-being of the member. Steps must be taken by MCOs to ensure access to services, appropriately transfer medical information, and facilitate a smooth transition of care, thereby promoting the health of the DMMA member.

This policy describes the processes and protocols used by the MCOs to assure continuity of care for a DMMA member.

Procedures

Transition of New Members

1. The Contractor shall develop a transition of care policy and procedures to support the transition of all new members (e.g., new Diamond State Health Plan [DSHP]/DSHP Plus members and members transferring from another MCO). The transition of care policy shall include, at a minimum, the requirements in 42 CFR 438.62(b)(1), 42 CFR 438.208(b)(2), and the requirements defined in this Section.

2. The Contractor's transition of new members shall minimize disruption to members' established relationships with providers and existing care treatment plan and ensure Medically Necessary Covered Services are provided in a timely manner.

3. For members that transfer MCOs during the Annual Open Enrollment Period, the State will notify the receiving and relinquishing MCO of the transfer.

4. The member or the Contractor can initiate the process of requesting a member's transfer to another MCO. All approved transfers will become effective no later than the first day of the second month after the transfer was requested. The Contractor will be notified of the member's transfer via the Contractor's 834 Enrollment File from the State.

5. The Contractor shall provide all required new member materials to all members within 10 business days of the member's enrollment date in the Contractor's MCO.

6. If a member is transferring from the Contractor to another MCO, the Contractor shall cooperate with the receiving MCO to ensure a seamless transition that is safe, timely, and orderly. For DSHP Plus long-term services and supports (LTSS) members and DSHP and other DSHP Plus members with high needs (as determined by the Contractor or the State), the Contractor shall complete the member transfer coordination of care form (specified by the State), share the completed form with the receiving MCO, participate in transition of care meetings (including transition meetings led by the State), and provide any additional needed information about the member. If the member is hospitalized at the time of enrollment with the other MCO, the Contractor shall be responsible for inpatient facility payments until the member is discharged.

7. If a new member transferring from another MCO to the Contractor is hospitalized at the time of enrollment, the originating MCO shall be responsible for inpatient facility's payment until the member is discharged. However, the Contractor shall be responsible for payments for professional services as of the member's enrollment date, participating in discharge planning, and providing all covered services upon discharge.

8. For members transferring from another MCO, the Contractor shall cooperate with the relinquishing MCO to ensure a seamless transition that is safe, timely, and orderly. For members with high needs (as determined by the Contractor or the State), the Contractor shall receive the member transfer coordination of care form (specified by the State) and participate in transition of care meetings, including transition meetings led by the State.

9. For treatment (other than prenatal services to a pregnant member in the second or third trimester and the provision of services in the DSHP Plus LTSS benefit package) of a medical or behavioral health condition or diagnoses that is in progress or for which a prior authorization for treatment has been issued, the

Contractor must cover the service from the treating provider if the provider is located within the distance standards specified in the Master Services Agreement (MSA) for the lesser of 90 calendar days after the member's enrollment date or until the treating provider releases the member from care. The Contractor shall assist the member in transitioning to a participating provider after this period, as specified in the MSA.

10. If the member is a pregnant woman in her second or third trimester, the Contractor shall cover prenatal services from the treating provider if located within the distance standard in the MSA through 60 calendar days postpartum. If the treating provider is not located within the distance standards specified in **Section 3.9.15.2 of the MSA**, the Contractor must cover the service. However, after a period of 30 calendar days, the member may be required to transfer to a qualified provider that is located within the distance standards specified in the MSA. The Contractor shall assist the member in transitioning providers, as specified in the MSA.

11. For services in the DSHP Plus LTSS benefit package, the Contractor shall continue the services authorized by the transferring MCO, in accordance with the approved nursing facility level of service/plan of care, regardless of whether the treating providers are participating or non-participating providers, for a minimum of 30 calendar days after the member's enrollment date. Thereafter, the Contractor shall not reduce these services unless a case manager has conducted a comprehensive needs assessment, developed a plan of care, and the Contractor has authorized and initiated services in the DSHP Plus LTSS benefit package in accordance with the member's new plan of care, which may include transition from non-participating to participating providers.

12. For members under age 18 transferring to the Contractor from another MCO who are receiving behavioral health services from Department of Services for Children, Youth and Their Families (DSCYF) or Division of Developmental Disabilities Services (DDDS) or are close to the 30 unit limit on outpatient behavioral health services, the Contractor shall contact DSCYF, in accordance with the Contractor's protocol with DSCYF/DDDS, as outlined in the MSA, Behavioral Health Services for Children.

13. For members transferring to the Contractor from another MCO who also participate in Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE), the Contractor shall contact Division of Substance Abuse and Mental Health (DSAMH), in accordance with the Contractor's protocol with DSAMH, as outlined in the MSA, Behavioral Health Services provided by DSAMH to adults in PROMISE.

14. For members transferring to the Contractor from another MCO who are enrolled in the DDDS Lifespan Waiver, the Contractor shall contact DDDS, in accordance with DDDS' processes, within two business days in order to provide the name and contact information of the Contractor's point of contact to facilitate seamless transition, care coordination, and continuity of care.

15. <u>For Justice-Involved Members:</u>

    A. Members who become inmates of a Delaware Department of Corrections (DOC) correctional facility retain their Medicaid eligibility and enrollment with the Contractor but are assigned to a special benefit plan. Members assigned to this special benefit plan will not be disenrolled from the Contractor, but the State will not make payments to the Contractor until the member is released. The State may enroll clients who are determined eligible for Medicaid while they are inmates of a DOC correctional facility into the Contractor's MCO, and the Contractor shall be responsible for these members upon their release.

    B. To support the State's initiative to improve outcomes for Medicaid-eligible individuals transitioning from a DOC correctional facility, the Contractor shall:

        i. Collaborate with the DOC to identify members with chronic and/or complex physical and/or behavioral health care needs prior to the member's release.

        ii. Identify a single point of contact to coordinate activities with the Delaware DOC and other State agencies.

        iii. Engage in care coordination as specified by the State.

        iv. Immediately notify the State upon becoming aware that a member may be an inmate of a DOC correctional facility and the member's enrollment has not been changed to the special benefit plan.

16. The Contractor shall collaborate with the justice system and participate in any State initiatives for justice-involved members, as specified by the State.

17. Except as provided below regarding members enrolling as of the Start Date of Operations, for new DSHP Plus LTSS members, the Contractor shall conduct an onsite visit, develop a plan of care, and begin delivery of services in the DSHP Plus LTSS benefit package in accordance with the timeframes specified in the

MSA.

18. For DSHP Plus LTSS members enrolling as of the Start Date of Operations:

    A. If the initial onsite visit will not occur within 10 business days of the Start Date of Operations, the Contractor shall send the member written notification within 10 business days of the Start Date of Operations that explains how the member can reach the Contractor's case management unit for assistance with questions or concerns pending the onsite visit.

    B. The Contractor shall conduct the initial onsite visit for new Home- and Community-Based Services (HCBS) members within 90 calendar days of the Start Date of Operations, develop and approve a plan of care, and provide services in the member's new plan of care, within 14 calendar days of the initial onsite visit.

    C. The Contractor shall conduct the initial onsite visit for new DSHP Plus LTSS members residing in a nursing facility within six months of the Start Date of Operations. The Contractor shall also meet with nursing facilities and assisted living facilities to discuss the current status and needs of new members within 30 calendar days of the Start Date of Operations.

    D. The Contractor shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the Contractor without any disruption in services.

    E. If at any time before the onsite visit occurs, the Contractor becomes aware of a change in a member's needs (e.g., from the State's pre-admission evaluation or the Contractor's initial contact with the member), a case manager shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the Contractor shall initiate the change in services within 10 business days of becoming aware of the change in the member's needs. In emergency situations (e.g., the member's informal caregiver is admitted to the hospital), the Contractor shall initiate immediate, necessary changes in service.

19. <u>For Pharmacy Members:</u>

    A. The Contractor's transition of care policy and procedures shall include procedures for continuity of care of prior authorized pharmacy services for new members.

B. The Contractor shall ensure that members can continue treatment of any medications with prior authorization by the State through the greater of: (i) the expiration date of active prior authorization by the State's FFS pharmacy program and (ii) the applicable timeframe (60 or 90 calendar days) for medications not prior authorized by the State.

C. For non-behavioral health diagnoses, the Contractor must provide a continuity/transition period of at least 60 calendar days for medications prescribed by a treating provider that were not prior authorized by the State's FFS pharmacy program.

D. For behavioral health diagnoses, the Contractor must provide a continuity/transition period of at least 90 calendar days for medications prescribed by the treating provider for the treatment of the specific behavioral health diagnosis that were not prior authorized by the State's FFS pharmacy program.

20. For Dental Members:

A. The Contractor's transition of care policy and procedures shall include procedures for continuity of care of prior authorized dental services for new members.

Transition Between Providers

1. The Contractor shall actively assist members in transitioning to another provider when there is a change in providers. The Contractor shall use a person-centered approach to providing assistance based on an evaluation of the member's needs before and during the transition. The evaluation should consider the member's medical needs (e.g., members with chronic or acute medical or behavioral health conditions, members who are receiving LTSS, and members who are pregnant) and Health-Related Social Needs impacting the transition.

2. Based on the member's needs, the Contractor's assistance could include helping the member locate another participating provider that can meet the member's needs, providing assistance with scheduling appointments, providing information about the transition, providing contact information for the new provider, and supporting medical records transfers. For DSHP Plus LTSS members, the member's case manager shall provide this assistance. For members receiving care coordination, the member's care coordinator shall provide this assistance. For PROMISE participants, the Contractor shall coordinate with the DSAMH care manager as appropriate to assist the member to transition between providers. For members enrolled in the DDDS Lifespan Waiver, the Contractor shall

coordinate with the DDDS case manager as appropriate to assist the member to transition between providers.

3. Except in cases where the provider was terminated by the Contractor for cause, if a provider is no longer a participating provider, the Contractor shall provide continuation of such provider for a lesser of a period of 90 calendar days or until the treating provider releases the member from care.

4. The Contractor shall ensure that, at a minimum, its provider transition process includes the following:

    A. A process that ensures a transfer does not create a lapse in services, including an appropriate schedule for transitioning members when there is medical necessity for ongoing care.

    B. A requirement that an HCBS provider that is no longer willing or able to provide services to a DSHP Plus LTSS member to cooperate with the member's case manager to facilitate a seamless transition to another HCBS provider and continue to provide services to the member until the member has been transitioned to the other provider.

    C. A mechanism for timely information exchange.

    D. A mechanism for assuring confidentiality.

    E. A mechanism for allowing a member to request and be granted a change of provider at no cost to the member.

5. <u>For DSHP Plus LTSS members:</u>

    A. The Contractor shall not transition residents of a nursing facility or assisted living facility to another facility unless:

        i. The member or member representative specifically requests to transition to another facility, which shall be documented in the member's file.

        ii. The member or member representative provides written consent to transition to another facility based on quality or other concerns raised by the Contractor, which shall not include the facility's rate of reimbursement.

iii. The facility where the member resides is not a participating provider.

B. If the Contractor intends to transfer a member because the facility where the member currently resides is not a participating provider, the Contractor shall provide continuation of services in such facility for at least 30 calendar days, which shall be extended as necessary to ensure continuity of care pending the facility becoming a participating provider or the member's transition to a participating facility.

i. The Contractor shall not transition nursing facility residents to a community-based setting unless the member chooses, as part of the placement process, to receive HCBS as an alternative to nursing facility care.

Transition to DSHP Plus LTSS

1. The Contractor shall ensure that if a member transitions to DSHP Plus LTSS the process is seamless to the member. This includes, but is not limited to:

A. Transferring all member information as necessary so that Contractor staff interacting with a member who has transitioned to DSHP Plus LTSS has access to all available information about the member as needed to provide appropriate assistance and to limit requests for information from members.

B. Ensuring that authorizations for services in the DSHP benefit package continue when a member transitions to DSHP Plus LTSS.

C. Informing members of any changes as a result of transition to DSHP Plus LTSS, including, but not limited to, covered services and additional services and access to a case manager.

D. Identifying when a DSHP member is reaching the 30-calendar day nursing facility limit in the DSHP benefit package and coordinating with the nursing facility to assist the member in applying for DSHP Plus LTSS.

Transition when In Lieu of Services are Terminated

1. The Contractor shall ensure that State plan services and settings are provided timely and with minimal disruption to care to any enrollee who is currently receiving the ILOS that will be terminated.