520 - MEMBER TRANSITIONS

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I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP (CHP), and DES/DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), DES/DDD Tribal Health Program (DDD THP), Tribal ALTCS, TRBHAs, and all FFS populations, excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes requirements for Contractors and FFS Programs regarding Member Transitions.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy:

CUSTOMIZED MEDICAL EQUIPMENT	**ENROLLMENT TRANSITION INFORMATION (ETI)**	**HEALTH CARE DECISION MAKER (HCDM)**
MEDICAL MANAGEMENT (MM)	**MEMBER**	**MEMBER TRANSITION**
QUALITY OF CARE (QOC)	**SPECIAL HEALTH CARE NEEDS**	

III. POLICY

A. MEMBER TRANSITIONS

The Contractor shall identify and facilitate coordination of care for all AHCCCS members during transitions between Contractors, FFS Programs, FFS members transitioning to a Managed Care Organization (MCO), members transitioning to FFS, as well as changes in service areas, subcontractors, and/or health care providers. The Contractor shall implement a transition of care policy as specified in 42 CFR 457.1216, 42 CFR 438.62.

The Contractor shall receive transitioning FFS member information via automated electronic transfer file accessible through the AHCCCS Secured File Transfer Protocol (SFTP Server).

Members with special health care needs or circumstances may require additional or distinctive assistance during a period of transition to ensure members do not experience a gap in services. Policies and procedures shall be developed by the Contractor to address these situations.

Special circumstances include but are not limited to the following:

1. Members who are pregnant (especially pregnant women who are high risk or in their third trimester).

2. Members in the process of having major organ or tissue transplantation services.

3. Members who are on a high-cost specialty drug or biologic.

4. Members who are being considered for or are actively engaged in a transplant process and for up to one-year post transplant.

5. Members with a chronic illness, which has placed the member in a high-risk category and/or resulted in emergency department utilization, hospitalization, or placement in nursing care, or other facilities.

6. Members with significant medical or behavioral health conditions (e.g., diabetes, asthma, hypertension, depression, or serious mental illness) that require ongoing specialist care and appointments.

7. Chemotherapy and/or radiation therapy.

8. Dialysis.

9. Members hospitalized at the time of transition.

10. Members with ongoing needs such as:
    a. Medical equipment including ventilators and other respiratory assistance equipment,
    b. Home care services, such as attendant care or home health,
    c. Medically necessary transportation on a scheduled and/or ongoing basis,
    d. Prescription medications (including those that have been stabilized through a step therapy process), and/or
    e. Pain management services.

11. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media.

12. Members with qualifying Children's Rehabilitative Services (CRS) conditions.

13. Members with qualifying CRS conditions transitioning to adulthood.

14. Members diagnosed with Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS).

15. Members enrolled in the ALTCS (EPD and DDD) or Tribal ALTCS program.

16. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP).

17. Members with a Serious Mental Illness (SMI) designation.

18. Any child that has an assessed need that is equivalent to an Early Childhood Service Intensity Instrument/Child and Adolescent Level of Care Utilization System (ECSII/CALOCUS) score of 4, 5 or 6.

19. Members who have a current Seriously Emotionally Disturbed (SED) diagnosis flag in the system or who qualified for the SED designation through the SED Eligibility Determination process in the AHCCCS system.

20. Substance exposed newborns and infants diagnosed with Neonatal Abstinence Syndrome (NAS).

21. Members diagnosed with Severe Combined Immunodeficiency (SCID).

22. Members with a diagnosis of autism or who are at risk for autism.

23. Members diagnosed with Opioid Use Disorder (OUD), separately tracking pregnant women and members with co-occurring pain and opioid use disorder.

24. Members enrolled with Division of Child Safety (DCS)/Comprehensive Health Program (CHP).

25. Members who transition out of the CHP up to one-year post transition.

26. Members identified as a High Need/High Cost member.

27. Members on conditional release from Arizona State Hospital (ASH).

28. Other services not indicated in the State Plan for eligible members but covered by Title XIX/XXI for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible members, including members whose conditions require ongoing monitoring or screening.

29. Members who at the time of their transition have received Prior Authorization (PA) or approval for:
    a. Scheduled elective surgery(ies),
    b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits,
    c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the 30-day period,
    d. Behavioral health services,
    e. Appointments with a specialist located out of the Contractor service area, and
    f. Nursing facility admissions.

Contractor requirements regarding member transitions between AHCCCS Contractors for Annual Enrollment Choice (AEC) and eligibility changes refer to ACOM Policy 402.

B. NOTIFICATIONS REQUIRED OF CONTRACTORS

1. The relinquishing Contractor shall provide relevant information regarding members who transition to a receiving Contractor or a FFS Program. The Enrollment Transition Information (ETI) Form shall be utilized for transfer of information for at least those members with special circumstances, listed in this policy, who are transitioning enrollment to another Contractor or an FFS Program.

2. There are two specific ETI forms:
   a. Attachment A of this Policy, and
   b. AMPM Exhibit 1620-9 used by ALTCS Contractors and the Tribal ALTCS program.

3. The relinquishing Contractor shall complete and electronically transmit the appropriate ETI Form to the receiving Contractor or FFS Program no later than 10 business days from date of receipt of AHCCCS notification.

4. The relinquishing Contractor who fails to notify the receiving Contractor or FFS Program of transitioning members with special circumstances will be responsible for covering the members' care for up to 30 days following the transition.

5. The Contractor shall provide protocols for the transfer of pertinent medical records, as discussed in this Policy, and arrange for the timely notification to members, subcontractors, or other providers, as appropriate during times of transition.

6. The receiving Contractor shall provide new members with a Member Handbook, provider directory, and emergency numbers as specified in ACOM Policy 406.

7. The receiving Contractor or FFS Program shall follow-up as appropriate to address the needs of the member identified on the ETI Form.

8. The receiving Contractor shall extend previously approved PAs for a minimum period of 30 days from the date of the member's transition unless a different time period is mutually agreed to by the member or member's Health Care Decision Maker (HCDM)/ Designated Representative (DR).

9. The receiving Contractor shall provide at a minimum a 90-day transition period, for children and adults with special health care needs who have an established relationship with a Primary Care Provider (PCP) that does not participate in the Contractor's provider network. During this transition period the member may continue to seek care from their established PCP while the member/ HCDM, DR, the Contractor care manager and/or ALTCS Contractor case manager or provider case manager identifies an alternative PCP within the new Contractor's provider network.

   For members who transition to an ACC-RBHA from an ACC Contractor, and who have an established relationship with a PCP that does not participate in the ACC-RBHAs provider network, the ACC-RBHA shall provide, at a minimum, a six-month transition period. During this transition period, the member may continue to seek care from their established PCP while the member/HCDM/DR, the ACC-RBHA, and/or case manager finds an alternative PCP within the new ACC-RBHAs provider network. Refer to ACOM Policy 402.

C. TRANSITION TO ALTCS

If a member is referred to and approved for ALTCS enrollment, the relinquishing Contractor shall coordinate the transition with the receiving ALTCS Contractor or Tribal ALTCS.

The Contractor shall ensure applicable protocols are followed for any special circumstances of the member, and that continuity and Quality of Care (QOC) is maintained during and after the transition.

Refer to ACOM Policy 402 and AMPM Policy 1620 for ALTCS Contractor responsibilities in the transition process.

D. TRANSITION FROM CHILD TO ADULT SERVICES

Transitions involving co-occurring behavioral and physical health conditions shall include, at a minimum the following:

1. Coordination between child providers and the anticipated adult providers, including development of a transition plan for the member that focuses on assisting the member with gaining the necessary skills and knowledge to become a self-sufficient adult and facilitates a seamless transition from child services to adult services.

2. A process that begins no later than when the child reaches the age of 16.

3. Based on clinical presentation or at the request of the HCDM, an SMI eligibility determination is completed when the adolescent is at least the age of 17.5 years old and lives in Arizona or plans to live in Arizona.

4. Any additional stakeholder, behavioral or physical healthcare entity involved with the child shall be included in the transition process, as applicable (e.g., DDD, juvenile justice system, CHP, education system).

5. A coordination plan to meet the unique needs for members with special health care needs, including members with CRS designation, as specified in Contract. Additionally, the AMPM Behavioral Health Practice Tools, Chapter 200, shall be utilized.

6. Licensed Health Aide (LHA) services provided to a member enrolled in ALTCS and under age 21 require transitioning planning and communication to families prior to the member's 21st birthday. LHA services are not available to members 21 years and older. Refer to AMPM Policy 1240-G and A.A.C. R4-19-901.

E. MEMBERS HOSPITALIZED DURING AN ENROLLMENT CHANGE

The Contractor shall make provisions for the transition of care for members who are hospitalized on the day of an enrollment change. The provisions shall include processes for the following:

1. Notification to the receiving Contractor or FFS Program prior to the date of the transition, for continued authorization of treatment and service coordination.

2. Notification to the hospital and attending physician of the transition by the relinquishing Contractor. The relinquishing Contractor shall notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving Contractor or FFS Program for authorization of continued services. If the relinquishing Contractor fails to provide notification to the receiving Contractor, hospital, and the attending physician, relative to the transitioning member, the relinquishing Contractor shall be responsible for coverage of services rendered to the hospitalized member for up to 30 days. This includes, but is not limited to, elective surgeries for which the relinquishing Contractor issued prior authorization.

3. Per Diagnosis Related Group (DRG) rules, the Contractor in which the member is enrolled upon discharge is responsible for the stay.

4. Coordination with providers regarding activities relevant to concurrent review and discharge planning shall be addressed by the receiving Contractor or FFS Program.

   Refer to AMPM Policy 530 for transfers between hospitals.

F. TRANSITION DURING MAJOR ORGAN AND TISSUE TRANSPLANT SERVICES

1. If there is a change in Contractor or FFS enrollment, both the relinquishing and receiving Contractor and/or FFS Program are responsible for coordination of care and coverage for members who have been approved for major organ or tissue transplant. The relinquishing Contractor or FFS Program is responsible for contracted components up to and including, completion of the service components that the member is receiving at the time of the change. The receiving Contractor or FFS Program is responsible for the remainder of the components of the transplant.

2. For continuation of previously approved transplant reinsurance, the receiving Contractor shall submit to AHCCCS/Medical Management (MM), a request for transplant reinsurance, as specified in Contract.

3. If a member changes to a different Contractor while undergoing transplantation at a transplant center that is not an AHCCCS contracted provider, each Contractor is responsible for its respective dates of service. If the relinquishing Contractor has negotiated a special rate, it is the responsibility of the receiving Contractor to coordinate the continuation of the special rate with the respective transplant center.

G. ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT FOR SIGNIFICANT MEDICAL CONDITIONS

1. The Contractor shall have protocols for ongoing care of members with active and/or chronic health care needs (e.g., outpatient chemotherapy, home dialysis, behavioral health needs, and pregnancy) during the transition period. The receiving Contractor shall have protocols to address the timely transition of the member from the relinquishing PCP to the receiving PCP, to maintain continuity of care.

2. Pregnant women who transition to a new Contractor within the last trimester of their expected date of delivery shall be allowed the option of continuing to receive services from their established physician and anticipated delivery site through the postpartum visits included in the all-inclusive maternity care as specific in AMPM Policy 410.

H. TRANSITION OF MEDICALLY NECESSARY TRANSPORTATION

The Contractor shall have processes for at least the following:

1. Provision of information to new members on what, and how, medically necessary transportation can be obtained.

2. Provision of information to providers on how to order medically necessary transportation.

I. TRANSITION OF PRESCRIPTION MEDICATION SERVICES

The Contractor shall address the dispensing and refilling of prescription medications during the transition period as follows:

1. The relinquishing Contractor shall cover the dispensation of the total prescription amount of either continuing or time-limited medications, if filled at or before midnight on the last day of enrollment. The relinquishing Contractor may not reduce the quantity of the ordered prescription unless it exceeds a 30-day supply or 100-unit doses.

2. The receiving Contractor or FFS Program shall extend previously approved PA for a period of 30 days from the date of the member's transition unless a different time period is mutually agreed to by the member or member's HCDM/DR.

3. Members transitioning to a PCP for behavioral health medication management shall continue the medication(s) previously prescribed until the member can transition to their new PCP. The Contractor shall coordinate the care and ensure that the member has a sufficient supply of behavioral health medications to last through the date of the member's first appointment with their new PCP. Members receiving behavioral health medications from their PCP may simultaneously receive counseling and other medically necessary services.

Refer to AMPM Policy 310-V for complete information regarding prescription medication coverage.

J. DISPOSITION OF MEDICAL EQUIPMENT, APPLIANCES, AND MEDICAL SUPPLIES DURING TRANSITION

The Contractor and Tribal ALTCS shall address the disposition of medical equipment, appliances, and supplies during a member's transition period and develop policies that include the following:

1. Non-Customized Medical Equipment:
   a. The relinquishing Contractor and Tribal ALTCS shall provide adequate information about members with ongoing medical equipment needs to the receiving Contractor and/or FFS Programs.

2. Customized Medical Equipment:
   a. Customized Medical Equipment purchased for members by the relinquishing Contractor will remain with the member after the transition. The purchase cost of the equipment is the responsibility of the relinquishing Contractor,
   b. Customized Medical Equipment ordered by the relinquishing Contractor but delivered after the transition to the receiving Contractor shall be the financial responsibility of the relinquishing Contractor, and
   c. Maintenance contracts for Customized Medical Equipment will transfer with the member to the new Contractor. Contract payments due after the transition will be the responsibility of the receiving Contractor, if the receiving Contractor elects to continue the maintenance contract. For FFS Programs, FFS Program rates apply.

3. Augmentative Communication Devices:
   a. A 90-day trial period is generally necessary to determine if the Augmentative Communication Device (ACD) will be effective for the member, or if it should be replaced with another device,
   b. If a Member Transitions from a Contractor during the 90-day trial period, one of the following shall occur:
      i. If the ACD is proven to be effective, the device will remain with the member. Payment for the device is the responsibility of the relinquishing Contractor. The cost of any maintenance contract necessary for the ACD shall be the responsibility of the receiving Contractor, if the receiving Contractor elects to continue the maintenance contract. For FFS Programs, FFS Program rates apply, or
      ii. If the ACD is proven to be ineffective, it shall be returned to the vendor. The receiving Contractor shall then coordinate a new device trial and purchase if it is determined to meet the member's needs.

   Note: If the member has had the ACD for more than a 90-day trial period, the Customized Medical Equipment process applies.

K. MEDICAL RECORDS TRANSFER DURING TRANSITION

To ensure continuity of member care during the time of enrollment change, the Contractor shall ensure timely transition of medical records. Medical records are applicable to both paper and electronic medical records. If an organization distributes information electronically, it must indicate that the information is available in paper format upon request. Refer to AMPM Policy 940 for additional information.

L. REFERRALS RESULTING IN OUT-OF-SERVICE AREA PLACEMENT FOR MEMBERS WITH AN SMI DESIGNATION

1. When an ACC-RBHA Contractor initiates a referral for placement of a member with an SMI designation to a service provider in another ACC-RBHA Contractor's service area for the purposes of obtaining behavioral health services, the resulting relocation of the member may result in the eligibility source making corresponding changes to a member's address in the Pre-paid Medicaid Management Information System (PMMIS). A change of address to another Geographic Service Area (GSA) will cause the member with an SMI designation to become enrolled with an ACC-RBHA Contractor in the other GSA for both behavioral health and physical health services.

2. The ACC-RBHA Contractor who made the referral for the out-of-area placement shall take steps to ensure retention of the member's behavioral assignment and physical health enrollment as well as financial responsibility for both behavioral and physical health services during the period the member is placed out of the ACC-RBHA Contractor's service area:
   a. The referring ACC-RBHA Contractor is responsible for completing and submitting an Out-of-Area Placement Request utilizing Attachment B of this Policy to ensure AHCCCS is aware of and can flag the member in the AHCCCS system as being in an out-of-area placement,
   b. AHCCCS will utilize the submitted documentation to update the member's record with an indicator that will bypass the automatic PMMIS changes to the member's behavioral health assignment and physical health enrollment. The normal automatic activation would otherwise change a member's behavioral health assignment and physical health enrollment, due to an out-of-GSA address change, and
   c. The referring ACC-RBHA Contractor is responsible for submitting Attachment B in its entirety and for any extension or change to the effective date of placement and/or end date of placement to ensure that the indicator remains in effect only as appropriate.

3. When a member is placed in an out-of-area placement the referring ACC-RBHA Contractor shall establish contracts with out-of-area service providers for behavioral health and physical health services and authorize payment for behavioral health services and physical health services.

4. When the member returns to the original service area and another address change is processed in the PMMIS, the end date of the out-of-area placement will allow resumption of normal behavioral health assignment and physical health enrollment rules.

5. Members who are in an out-of-area placement for one year, from the latter of the date of the original out-of-area placement or from October 1, 2018, will be transitioned to the ACC-RBHA Contractor in the GSA of placement, unless otherwise approved by AHCCCS.