

520 – MEMBER TRANSITIONS¹

EFFECTIVE DATE: 10/01/1994, 07/01/16²

REVISION DATE: 12/11/14 — ~~03/01/2011, 11/01/07, 04/01/05, 10/01/01, 02/01/01, 07/22/96, 02/01/01, 10/01/01, 04/01/05, 11/01/07, 03/01/11,~~ 11/03/16³

I. PURPOSE

This Policy applies to Acute Care, ~~Arizona long-term care system~~ ~~elderly and physically disabled (ALTCS/ E/PD), children’s rehabilitative services (CRS), D-C-S-/CMDP children’s medical and dental program (CMDP), DES/department of economic security (DES), DDD (DDD), and RBHA Contractors; and Fee-For-Service (FFS) Programs including: Tribal ALTCS, TRBHAs, and the American Indian Health Program (AIHP), as delineated within Policy.4 This Policy does not apply to the following –FFS populations; including –HPE Hospital Presumptive Eligibility (HPE), FFS Temporary, FFS Permanent, Prior Quarter Coverage and Federal Emergency Services (FES). This Policy establishes guidelines for Contractors and FFS Programs regarding member transitions.~~

II. DEFINITIONS

CUSTOMIZED DME Equipment that has been altered or built to specifications unique to a member’s medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

ENROLLMENT TRANSITION INFORMATION Member specific information the Relinquishing Contractor must complete and transmit to the Receiving Contractor or FFS Program for those members requiring coordination of services as a result of transitioning to another Contractor or FFS Program.

MEMBER TRANSITION The process during which members change from one Contractor or Fee For Service Program⁵ to another.

III. POLICY

A. MEMBER TRANSITIONS

Contractors ~~must~~ shall identify and facilitate coordination of care for all AHCCCS members during ~~changes or~~ transitions between Contractors, FFS

¹ Information for DBHS Policy 901 has been considered for merger in this Policy

² Arizona Laws 2015, Chapter 19, Section 9 (SB 1480) enacts that from and after June 30, 2016, the provision of behavioral health services under DBHS in the Department of Health Services is transferred to and shall be administered by the AHCCCS

³ Revised date order, 11-3-16 is date presented at APC

⁴ Updated with applicability for Policy 520

⁵ Clarification

~~Program~~ ~~see or~~ ~~ervice~~ (FFS)⁶, as well as changes in service areas, subcontractors, and/or health care providers. Members with special circumstances (~~such as those listed below~~) may require additional or distinctive assistance during a period of transition. Policies ~~or~~ ~~and~~ ~~protocols~~ ~~procedures~~⁷ ~~must~~ ~~shall~~ be developed to address these situations.

Special circumstances include members designated as having “special health care needs” under ~~AMPM Policy 540-~~⁸ ~~of this Chapter, as well as members who have including but not limited to the following:~~⁹

~~Medical conditions or special circumstances such as:~~¹⁰

- a. Pregnancy (especially women who are high risk ~~and or in their~~ third trimester,¹¹ ~~or are within 30 days of their anticipated delivery date~~)¹²
- b. Major organ or tissue transplantation services which are in process.
- c. Chronic illness, which has placed the member in a high-risk category and/or resulted in ~~emergency room~~ ~~department~~ ~~utilization~~,¹³ hospitalization or placement in nursing, or other facilities, and/or
- d. Significant medical ~~or behavioral health~~ ~~or chronic~~ conditions (e.g., diabetes, ~~asthma~~, hypertension, ~~or depression~~, ~~or serious mental illness~~ ~~pain control~~ ~~or orthopedics~~) that require ongoing specialist care and appointments.¹⁴

~~2. Members who are in treatment receiving services such as:~~

~~a.e.~~ Chemotherapy and/or radiation therapy, ~~or~~

~~f.~~ Dialysis, ~~or~~

~~b.g.~~ Hospitalization~~ed~~ at the time of transition.¹⁵

⁶ Clarification of inclusion for Fee For Service Programs, revised to align with policy formatting and terminology.

⁷ Clarification

⁸ Clarification

⁹ Revised. 11-3-16 APC correction to this section to remove duplicative language regarding around special circumstances

¹⁰ Revised to clarify special circumstances.

¹¹ Clarification

¹² Deleted, not necessary, clarification.

¹³ Clarification

¹⁴ Letter “d” added specific conditions, language from Division of Behavioral Health Services Policy revised to align with policy terminology.

¹⁵ Clarification

~~e.a. Members with ongoing needs such as:~~

~~d. —~~

h. ~~Members with ongoing needs such as:~~

i. Durable medical equipment including ventilators and other respiratory assistance equipment.²

ii. Home care services, such as Attendant Care or Home Health.¹⁶

iii. Medically necessary transportation on a scheduled and/or ongoing basis.¹⁷

iv. Prescription medications (including those that have been stabilized through a step therapy process),¹⁸ and/or

v. Pain management services.¹⁹

i. Members who frequently contact AHCCCS, State and local officials, the Governor’s Office and/or the media.²⁰

j. Members enrolled with Division of Child Safety/Comprehensive Medical and Dental Program (CMDP).²¹

~~Members assigned to a “challenging member” care coordinator~~

~~Members identified as a “super-utilizer/High Need/High Cost member”, and/or~~

~~k. —~~

~~l. Members on conditional release from Arizona State Hospital,~~

~~Members identified as in need of behavioral health services who do not have a behavioral health open episode of care²²~~

~~3. —~~

~~a. —~~

m. i. Other services not indicated in the State Plan for eligible members, but covered by Title XIX and Title XXI for Early and Periodic Screening,

¹⁶ Clarification

¹⁷ Clarification

¹⁸ Clarification

¹⁹ Clarification

²⁰ Added for clarification, language take from acute care contract.

²¹ Added for conformity to current practice as Comprehensive Medical and Dental Program must complete an Enrollment Transition Information form for all members transitioning.

²² Conformity as this information is stated above (duplicative).

Diagnosis—Diagnostic and Treatment eligible members, including members whose conditions —require ongoing monitoring or screening
²³

- r. Members who at the time of their transition have received prior authorization or approval for:
 - i. Scheduled elective surgery(ies).
 - ii. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits.
 - iii. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the ~~thirty~~30-day period.
 - iii.iv. Behavioral health services.²⁴
 - iv.v. Appointments with a specialist located out of the Contractor service area, and
 - vi. Nursing facility admissions.

Members who frequently contact AHCCCS, State and local officials, the Governor’s Office and/or the media.²⁵

For Contractor Requirements for member transitions between AHCCCS Contractors for Annual Enrollment Choice (AEC) and eligibility changes see ACOM Policy 402.

A.B. NOTIFICATIONS REQUIRED OF CONTRACTORS

- ~~1.~~ Relinquishing Contractors ~~must~~ shall provide relevant information regarding
 - 1. ~~members who transition to a receiving Contractor~~ or a FFS Program. The Enrollment Transition Information (ETI) ~~F~~form ~~must~~ shall be utilized for transfer of information ~~transmitted electronically~~ sent²⁶ for at least those members with special circumstances, listed in this ~~P~~policy, ~~—~~who are transitioning enrollment to another Contractor or a FFS Program. ~~—~~ There are ~~three~~ two²⁷ specific ETI forms:

²³ Added for Early and Periodic Screening Diagnosis and Treatment inclusion and clarification.

²⁴ Added “d” from Division of Behavioral Health Services Policy, revised to align with policy formatting and terminology.

²⁵ Moved to “3.f” for clarification and conformity.

²⁶ Updated to remove electronic submission requirement, clarification.

²⁷ Updated attachment information and clarification of forms and utilization.

~~a. Exhibit 520-1 Attachment A, Acute Care Enrollment Transition Information Form (ETI) Form is used by the Acute Care Contractors. Replace with the RFP DEF electronic file used for the Acute Transition~~

~~b.a.~~

~~Exhibit 520-2 CRS Enrollment Transition Information Form is used by the Arizona Department of Health Services, Children’s Rehabilitative Services (ADHS/CRS), when transitioning a member who is turning 21 years of age.²⁸~~

~~e.b. Chapter 1600 AMPM, Policy -1620, Exhibit 1620-9 Arizona Long Term Care System (ALTCS) Enrollment Transition Information Form, is used by ALTCS Contractors.~~

~~2. The relinquishing Contractor must complete and transmit the ETI to the appropriate parties no later than 10 business days of receipt of AHCCCS notification.²⁹~~

~~3. For individuals determined to have a Serious Mental Illness (SMI) who are transitioning from a Contractor to a Regional Behavioral Health Authority (RBHA) for provision of physical health services, there shall be a 14 day transition period in order to ensure effective coordination of care.³⁰~~

~~2.4. Relinquishing Contractors who fail to notify the receiving Contractor or FFS Programs of transitioning members with special circumstances, or fail to send the DEF file the completed ETI form, will be responsible for covering the member’s care resulting from the lack of notification, for up to 30 days following the transition.³¹~~

~~3. NOTE: CRS will notify the AHCCCS Contractor in writing 90 days prior to the member’s 21st birthday to ensure continuity of care. CRS is not financially responsible for an AHCCCS member on or after his/her 21st birthday.~~

~~4.~~

~~5. The AHCCCS Division of Member Services will notify a CRS member the month before the member’s 21st birthday of the opportunity to continue enrollment with the CRS Contractor, or enroll with another Acute Contractor. If a member does not respond, he or she will be disenrolled from the CRS Contractor at~~

~~6.~~

~~the end of their birth month. The member will be auto enrolled with~~

²⁸ ETI form 520-1 is to be used for both Acute and Children’s Rehabilitative Services (CRS), clarification.

²⁹ Added, Post 11-3-16 APC to include timeframe ETI is required.

³⁰ Post APC revision to include contractual requirement for members determined to have an SMI

³¹ Clarification

~~another Acute Contractor and will be given a 30-day choice period.~~³²

~~7.~~

~~8.5.~~ Contractors ~~must~~~~also~~shall provide protocols for the transfer of pertinent medical records, as discussed in this ~~p~~Policy, and arrange for³³ the timely notification ~~of to~~ members, subcontractors or other providers, as appropriate during times of transition.

6. Receiving Contractors ~~must~~shall provide new members with ~~their~~a member handbook, provider directory³⁴, and emergency numbers as specified in Contract and ACOM Policy 404.

~~9.7.~~ Receiving Contractors or FFS Programs ~~must~~shall follow ~~up~~ as appropriate for the needs identified ~~on~~ the ETI form.

B. C. AHCCCS TRANSITION POLICIES³⁵

~~AHCCCS has specific policy requirements policies for member transitions issues including, but not limited to:~~

~~Transition to an ALTCS Contractor from an Acute care Contractor~~

~~Transition to an Acute care Contractor from an ALTCS Contractor~~

~~County to county transitions~~

~~Transition to an acute care or ALTCS Contractor by a CRS member who is turning 21 years of age Acute care/ALTCS Contractor from the CRS Contractor~~

~~Transition from an Acute care Contractor to the CRS Contractor.~~

~~For children who have an established relationship with a PCP that does not participate in the CRS contractor's provider network, the CRS contractor will provide, at a minimum, a 90-day transition period in which the child may continue to seek care from their established PCP while the child and the child's parents and/or guardian, the CRS contractor, and /or case manager finds an alternative PCP within the CRS contractor's provider network.~~

~~Prior to the month a member will turn 21 years of age, the member will be notified of their choice to either continue enrollment with the CRS Contractor, or transition to an Acute care Contractor. If a member does not actively choose to remain with the CRS Contractor, the member will be disenrolled from the CRS Contractor at~~

³² Removed original revisions to this section, as it is for relinquishing contractor responsibilities. This language is in CRS Division of Member Services policies and has been moved to AMPM Policy 402 for clarification and conformity.

³³ Clarification

³⁴ Clarification

³⁵ Removed suggested language already addressed in this policy, clarification and conformity.

~~the end of the birth month. The member will be auto-enrolled with an Acute care Contractor.~~

~~Transition from the Acute care Contractor to the SMI Contractor~~

~~For individuals who have an established relationship with a PCP that does not participate in the integrated RBHA's provider network, the integrated RBHA will provide, at a minimum, a 90-day transition period in which the individual may continue to seek care from their established PCP while the individual, integrated RBHA, and/or case manager finds an alternative PCP within the integrated RBHA's provider network.~~

~~Transition of members hospitalized during an enrollment change³⁶~~

~~Transition during major organ and tissue transplantation services~~

~~Enrollment changes for members receiving outpatient treatment for significant conditions~~

~~Transfer and interim coverage of prescription medications~~

~~Disposition of durable medical equipment, orthotics, prosthetics and other medical supplies, and~~

~~Transfer of medical records~~

~~REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA) – TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA) TRANSITIONS~~

~~The relinquishing RBHA or TRBHA must coordinate care for individuals who are transitioning from one RBHA to another RBHA or to a TRBHA to receive behavioral health services.³⁷~~

D. TRANSITION TO ALTCS

If a member is referred to and approved for ALTCS enrollment, the ~~acute care~~relinquishing Contractor ~~must~~shall coordinate the transition with the ~~assigned-receiving~~ALTCS Contractor or Tribal ALTCS.³⁸

The

Contractors ~~to assure~~shall ensure³⁹ ~~that~~ applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition.

³⁶ Moved to ACOM Policy 402 for clarification and conformity.

³⁷ Removed, 11-3-16 APC correction to remove this section. Not necessary as policy as a whole applies to all contractors responsible for the provision of behavioral health services as well as physical health services.

³⁸ Clarification of responsibilities and added Tribal.

³⁹ Clarification

Refer to [ACOM Policy 402⁴⁰](#) and [AMP M Chapter 1600](#), Policy 1620 of ~~this Manual~~ for ALTCS Contractor responsibilities in the transition process.

~~TRANSITION TO ACUTE CARE CONTRACTOR FROM ALTCS CONTRACTOR~~

~~When a member becomes ineligible for ALTCS due to a voluntary withdrawal or the member fails the Pre Admission Screening (PAS), but remains eligible for the Acute Care program, the member will transition to an Acute Care Contractor. The ALTCS Contractor will receive a Potential Transition Listing (PTL) from AHCCCS that contains members who are being disenrolled. The ALTCS Contractor uses this list to identify transitioning members.~~

~~The ALTCS Contractor is responsible for:~~

- ~~1. Obtaining the member's health plan choice and submitting that choice to AHCCCS~~
- ~~Sending a completed the ETI form and any other appropriate information to the Acute Care Contractor~~
- ~~Coordinating care with the Acute Contractor in order that services are not interrupted~~
- ~~Involving the member's ALTCS case manager in the transition process⁴¹~~

~~If a member is determined through Pre Admission Screening (PAS) reassessment to no longer need long term care through ALTCS or the ALTCS Transitional program, and the member is determined eligible for a Acute Care enrollment, he/she will be transitioned to an acute care Contractor. The ALTCS Contractor will receive a Potential Transition Listing (PTL) prior plan list~~

~~for members that are being disenrolled. The ALTCS Contractor uses this list to identify transitioning members and needing an ETI form is completed and~~

⁴⁰ Added reference to ACOM 402 Transitions policy for clarification.

⁴¹ Removed as requirements are outlined in ACOM Policy 402, ACOM Policy 403 and ACOM Policy 426, clarification and conformity.

~~forwarded it and with any other appropriate information to the Acute Care Contractor. form must be completed for all ALTCS members. The member's ALTCS case manager must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained.~~

E. When receiving a transitioning member with special needs, the Acute Care Contractor is responsible for:

~~Acute care Contractors-~~

~~1. Coordinating care with the ALTCS Contractor in order that services are not interrupted~~

~~2. Evaluating the treatment plan and services the member is receiving~~

~~3. Authorizing all medically necessary acute care services-~~

~~must implement protocols for the special circumstances that members transitioning from ALTCS may experience. The following protocols must be included:~~

~~Conduct a comprehensive evaluation to determine the treatment and service regimen. The member must continue receiving the ALTCS treatment and service regimen until that determination is made. The exception is for ALTCS services that are not covered by acute care Contractors (e.g., attendant care or home delivered meals, etc.). The evaluation must encompass each service the member is currently receiving through the ALTCS Contractor.~~

~~Develop an individualized treatment plan based on the member's needs, past progress and projected outcomes, utilizing information gathered from the comprehensive evaluation, the PAS, the care plan, medical history, and information obtained from the ALTCS case manager See AMPM Chapter 1600.~~

GSATo GSA COUNTY TO COUNTY TRANSITIONS⁴²

~~Acute care If a member moves out of the Contractor's service area, the Contractors are is only responsible for coverage of emergency services for the members included on their member roster on the date the service was provided. This applies to members who have moved out of the acute care Contractor service area.~~

~~If an ALTCS member moves out of a service area, but not out of the state, the ALTCS Contractor(s) may remain responsible for all continue to provide non-emergency LTC services, if prior approval from the Contractor has been given, dependent upon whether the member is institutionalized or receiving home and community based services.~~

~~If a Contractor has service areas in multiple counties of the State and a member moves to a new service area that the Contractor serves, the member will remain enrolled with that Contractor. The Contractor is responsible for informing the members in writing that the member must submit any change in address must be submitted to the member's eligibility determination agency, at which point eligibility will be reevaluated.~~

~~The eligibility agency will send the address change to AHCCCS and the AHCCCS member file will be automatically updated with the correct address and enrollment locator code. There may be a different capitation rate in the new service area for that Contractor.~~

⁴² Language addressed in other policies on transition, clarification and conformity.

~~Contractors are responsible for the facilitation of enrollment transfers and ensuring that services for members are not interrupted. Upon becoming aware of the member's move.~~

~~CRS MEMBER TRANSITIONS~~⁴³

~~The AHCCCS Division of Member Services may terminate a member's enrollment with the CRS Contractor for several reasons. See ACOM Policy 426. If the member remains Title XIX or Title XXI eligible he/she will be transitioned to another AHCCCS Contractor~~

~~The CRS Contractor is responsible for transitioning CRS members under the following scenarios:~~

~~TRANSITION FROM CRS TO AN ALTCS CONTRACTOR~~

~~When a CRS member is referred to and approved for ALTCS enrollment, the CRS Contractor must coordinate the transition with the assigned ALTCS Contractor to assure that applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition. CRS members who transition to ALTCS EPD are no longer enrolled in CRS.~~

~~Transition from CRS to an Acute Care/ALTCS Contractor When a CRS member is Turning 21 Years of Age~~

~~When a CRS member does not notify the AHCCCS CRS Enrollment Unit regarding their decision to stay in CRS~~

~~Transition of Care from Pediatric Providers to Adult Providers when a CRS member chooses to remain enrolled with the CRS Contractor.~~

~~CRS enrolled members who choose to remain enrolled with the CRS Contractor at twenty one (21) years of age may require transition from his/her pediatric primary care and specialty providers to adult primary care and specialty providers. The CRS Contractor is responsible for assisting the CRS member in this transition. The CRS Contractor must follow 1. a through g below to ensure a smooth transition of care.~~

~~TRANSITION TO AN ACUTE CARE/ALTCS CONTRACTOR BY A CRS MEMBER WHO IS TURNING 21 YEARS OF AGE~~

~~AHCCCS special needs members who are under the care of CRS must be transitioned to an acute care/ALTCS Contractor on or after their 21st birthday. As a relinquishing Contractor, CRS must:~~

⁴³ Removed section CRS Member Transitions as requirements are outlined in CRS contract, clarification and conformity.

~~Initiate a transition plan by the age of twenty (20) 20 years which is ongoing until the member leaves the CRS program. The transition plan must:~~

~~Establish a transition plan that is age appropriate and addresses the current transition needs of the member (e.g., behavioral and physical (i.e., health condition management, developmental and functional independence, education, social and emotional health, guardianship, and transportation)⁴⁴~~

OPEN UNTIL 01-07-2017

⁴⁴ Removed section CRS Member Transitions as requirements are outlined in CRS contract and ACOM Policy 402 and ACOM Policy 426, clarification and conformity.

The transition plan shall:

Ensure families, members, and their primary care providers are part of the development and implementation of the transition plan

Include all teens, including those with cognitive disabilities, in a way that is meaningful to them

Include strategies to address barriers to transitioning from a pediatric to an adult-oriented system of care

Document the transition plan in the medical record

Provide family and the member with a copy of the transition plan

Establish a timeline for completing all services the member should receive through CRS prior to his or her twenty first birthday before the member transitions

Review and update the plan and timeline with member and family prior to official transition to adult provider⁴⁵

Advise the member's primary care provider of the discharge transition to an Acute Care and Contractor and ensure coordination of the services with with receiving the adult primary care provider.

Coordinate the transition plan with the appropriate entity appropriate Contractor:

AHCCCS aAcute care or ALTCS Contractors or

IHS and Tribal entities upon discharge from a CRS clinic and/or discharge from the CRS program.

Submit the CRS ETI form (Exhibit 520-21, CRS Enrollment Transition Information Form)) to the receiving (acute care or ALTCS) Contractor transition coordinator 90 days prior to the member's 21st birthday

Include medical records as appropriate

Coordinate with the receiving AHCCCS Contractor utilization management staff, hospital staff and PCP when the member is in the hospital on his/her 21st birthday at the time of transition, and

~~Be accountable for all other timeframes and processes noted in this policy as applicable.~~
MEMBERS HOSPITALIZED DURING AN ENROLLMENT CHANGE

1. ~~The~~ Contractor ~~s will~~shall ~~–~~make provisions for the ~~smooth~~ transition of care for members who are hospitalized on the day of an enrollment change. The provisions ~~must~~shall include ~~processes~~ protocols for the following:

~~a. –~~

~~b.a. Authorization of treatment by the receiving Contractor or FFS Program on an individualized basis. The receiving Contractor must address contracting for continued treatment with the institution on a negotiated fee basis if not part of the receiving Contractor’s provider network, as appropriate.~~

~~b. Reimbursement~~ Reimbursement diagnosis related group (DRG) payment as outlined in the AHCCCS All Patient Refined -Diagnosis Related Groups (APR-DRGs) RG Payment System Design Payment Policies on the AHCCCS website.~~The 46~~

c. Notification to the hospital and attending physician of the transition by the relinquishing Contractor. The relinquishing Contractor ~~must~~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 hospital and the attending physician relative to the transitioning member, the relinquishing Contractor ~~will~~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.

d. Coordination with providers regarding activities relevant to concurrent review and discharge planning ~~must~~shall be addressed by the receiving Contractor or FFS Program, along with the mechanism for notification regarding pending discharge.⁴⁷

~~Transfer of care to a physician and/or hospital affiliated with the receiving Contractor, when medically appropriate and safe for the member.~~⁴⁸~~Transfers from an out-of-network provider to one of the receiving Contractor providers cannot be made if harmful to the~~

⁴⁶ Clarification

⁴⁷ Concurrent review, discharge planning and coordination with providers is the mechanism, clarification.

⁴⁸ Clarification

~~member's health and must be determined medically appropriate. See~~

~~Chapter 530 of this Policy for transfers between hospitals. The transfer may not be initiated without approval from the relinquishing Contractor primary care provider, or the receiving Contractor Medical Director.~~

~~**NOTE:** Members in a Critical Care Units, Intensive Care Units, and or Neonatal Intensive Care Units requires close consultation between the attending physician and the receiving Contractor's physician. If a member is admitted to an inpatient facility while still assigned to the relinquishing Contractor, and discharged after transition to the receiving Contractor, both must work together to coordinate discharge activities.⁴⁹ See AMPM Policy 530 for transfers between hospitals.~~

~~The relinquishing Contractor will be responsible is responsible for coordination with the receiving Contractor regarding each specific prior authorized service. For members known to be transitioning, the relinquishing Contractor will not authorize hospital services such as elective surgeries scheduled less than 15 days prior to enrollment with the receiving Contractor. If authorized to be provided during this time frame, the service for the transitioning member will be the financial responsibility of the Contractor who authorized the service.~~

~~**NOTE:** CRS must notify the AHCCCS Contractor in writing 90 days prior to the member's 21st birthday to ensure coordination of care. CRS is not financially responsible for an AHCCCS member on or after his/her 21st birthday.⁵⁰~~

F. TRANSITION DURING MAJOR ORGAN AND TISSUE TRANSPLANTATION SERVICES

- ~~1. If there is a change in Contractor or FFS enrollment, both the relinquishing and receiving Contractors and/or FFS Program will be responsible for coordination of care and coverage for members awaiting who have been approved for⁵¹ major organ or tissue transplantation, from the time of transplantation evaluation and determination through follow-up care after the transplantation surgery. If a member changes Contractor enrollment while while undergoing transplantation at an AHCCCS-contracted transplant center, t⁵²The relinquishing Contractor or FFS Program is responsible for contracted components or modules stages of the service up to and including, completion of the service modules that stages components that the member is receiving at the time of the~~

⁴⁹ Clarification

⁵⁰ Removed section as requirements are outlined in ACOM Policy 402 and ACOM Policy 426, clarification.

⁵¹ Clarification

⁵² Clarification

change. The receiving Contractor or FFS Program –is responsible for the remainder of the module stages components of the transplantation service.⁵³

2. 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. Contractors must shall have protocols for ongoing care of members with active and/or chronic “high risk” special health care needs (e.g., outpatient chemotherapy, home dialysis, behavioral health needs⁵⁴, etc.) members—conditions—and pregnant memberspregnancy during the transition period. The receiving Contractor must shall have protocols to address the timely transition of the member from the relinquishing pPrimary eCare Pprovider (PCP) to the receiving PCP, in order to maintain continuity of care.

~~The receiving Contractor must address methods to continue the member's care, such as paying the AHCCCS fee schedule rates, contracting with or on a negotiated negotiating a rate basis with the member's current provider(s) and/or assisting members and providing instructions regarding their transfer to providers affiliated with the receiving Contractor.~~⁵⁵

2. ~~Receiving Contractors are also responsible for coordinating the transition of pregnant women to maintain continuity of care.~~ Pregnant women who transition to a new Contractor within the last trimester of their expected date of delivery must shall be allowed the option of continuing to receive services from their established physician and anticipated delivery site.

⁵³ Clarification

⁵⁴ Added from Division of Behavioral Health Services Policy, revised to align with policy terminology and conformity.

⁵⁵ Addressed in general notification and coverage requirements (30 days), clarification and conformity.

H. TRANSITION OF MEDICALLY NECESSARY TRANSPORTATION

~~Service delivery locations may necessitate changes in transportation patterns for the transitioning member.~~ Contractors ~~must~~ shall have ~~protocols~~ processes for at least the following⁵⁶:

1. Information to new members on what, and how, medically necessary transportation can be obtained
2. Information to providers on how to order medically necessary transportation.

~~Refer to Chapter 300 of this Manual for complete information regarding transportation service coverage.~~

~~Refer to Chapter 800 of this Manual for complete information regarding FFS transportation coverage.~~⁵⁷

I. TRANSITION OF PRESCRIPTION MEDICATION SERVICES

~~Acute Care Contractors are responsible for ensuring that the member's supply of psychotropic medications, including all federally reimbursable medications used to treat a behavioral health condition, is adequate to last through the date of the member's first appointment with a Behavioral Health Entity prescribing clinician. In the event of a delay or postponement of the member's appointment with the Behavioral Health Entity prescribing clinician, the Contractor must continue to cover the member's federally reimbursable psychotropic medications. Acute Care Contractors are responsible for forwarding all relevant member medical information to the Behavioral Health Entity prescribing clinician and that it is received prior to the first appointment.~~⁵⁸

Contractors ~~must~~ shall address the ~~issues of~~ dispensing and refilling of prescription medications during the transition period, ~~and develop protocols for~~ at least the following⁵⁹:

1. The r~~Relinquishing~~ Contractors ~~must~~ 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.⁶⁰

⁵⁶ Clarification and conformity.

⁵⁷ Clarification

⁵⁸ Clarification addressing chapter and Contractor transitions.

⁵⁹ Clarification

⁶⁰ Clarification to align with contract language.

- ~~1-2. The rReceiving Contractor or FFS Program shall extend previously approved prior authorizations 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 representative.⁶¹~~
- ~~2. Receiving Contractors must address prior authorization and refills of prescriptions within 3 days of the initial transition to the new Contractor member's transition. Post initial transition, prior authorization of prescription medication and refills of medication must be addressed within 14 days.~~
- ~~3. The relinquishing Contractor must provide the entire claims history and prior authorization files to the receiving Contractor. The provision of these files must be completed 30 days prior to the transition date. The remaining files for the last 30 days of the relinquishing Contractor's contract must be provide no later than 12:01 on the date of transition to the new Contractor.⁶²~~
- ~~4. The relinquishing Contractor must provide notice to the receiving Contractor's primary care provider of transitioning members who are currently taking prescription medications for medical conditions requiring ongoing use of medication, such as, but not limited to, immunosuppressant, psychotropic and cardiovascular medications, or unusually high cost medications."⁶³~~

~~Relinquishing Contractors must cover the dispensation of the total prescription amount of either continuing or time limited medications, if filled before midnight on the last day of enrollment. The relinquishing Contractor must also provide sufficient continuing medications for up to 15 days after the transition date.~~

~~Receiving Contractors must address prior authorization of prescription medication and refills of maintenance medication within 14 days of the member's transition.~~

~~The relinquishing Contractor must provide notice to the receiving Contractor primary care provider of transitioning members who are currently taking prescription medications for medical conditions requiring ongoing use of medication, such as, but not limited to, immunosuppressant, psychotropic and cardiovascular medications, or unusually high cost medications.~~

⁶¹ Clarification and conformity.

⁶² Clarification

⁶³ Removed this section since the receiving plan would not know the PCP at the time of transition for clarification.

~~NOTE: CRS will notify the AHCCCS Contractor in writing 60 days prior to the member's 21st birthday to ensure coordination of care. CRS is not financially responsible for a member's medications on or after his/her 21st birthday.⁶⁴~~

~~3. For members assigned to a RBHA who are transitioning to a PCP for the treatment of depression, anxiety and attention deficit/hyperactive disorder, the RBHA is responsible for ensuring that the member's supply of psychotropic medications used to treat the behavioral health condition is adequate to last through the date of the member's first appointment with the PCP. Members transitioning from an BHMP to a PCP for their behavioral health medication management shall be continued on the medication(s) prescribed by the BHMP until they the member can transition to their PCP. The AHCCCS Contractors and RBHA must 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 PCP. Members receiving behavioral health medications from their PCP may simultaneously receive counseling and other medically necessary services from the RBHA.⁶⁵~~

~~4. A person receiving methadone administration services who is not a recipient of take-home medication may receive up to two courtesy doses of methadone from a RBHA Contractor or TRBHA while the person is traveling out of the service area of the assigned RBHA Contractor or TRBHA.⁶⁶~~

~~a. All incidents of provision of courtesy dosing must be reported to the assigned RBHA or TRBHA.~~

~~b. The assigned RBHA Contractor or TRBHA must reimburse the RBHA Contractor or TRBHA providing the courtesy doses upon receipt of properly submitted bills or encounters.~~

~~c. Indian Health Services and Tribally owned or operated 638 facilities should refer to Chapter 12 of the IHS/Tribal Provider Manual for Methadone Administration Guidelines.~~

~~d. Fee For Service Providers should refer to Chapter 19 of the Fee-For-Service Provider Manual for Methadone Administration Guidelines.~~

⁶⁴ Language was deleted for accuracy and clarification. Medications are filled for 30 days as outlined in contracts; relinquishing Contractors don't know PCPs assigned in receiving Contractors; and members can chose to remain in CRS and then CRS is responsible for medications.

⁶⁵ Language taken from AMPM Chapter 300, Policy 310-V draft, clarification and conformity.

⁶⁶ [Section 4 merged from DBHS Policy and revised for clarification](#)

~~2.5.~~ Refer to AMPM Chapter 300 in this Manual for complete information regarding prescription medication coverage.

J. DISPOSITION OF DURABLE MEDICAL EQUIPMENT, ~~ORTHOTICS, PROSTHETICS~~ AND OTHER MEDICAL SUPPLIES DURING TRANSITION

Contractors ~~and Tribal ALTCS~~⁶⁷ ~~must~~ shall address the disposition of durable medical equipment (DME) and other medical equipment during a member's transition period and develop ~~protocols~~ policies that include the following:

1. Non-customized DME

~~The relinquishing Contractor and Tribal ALTCS must~~ shall provide adequate information about members with ongoing DME needs to the receiving Contractor and/or FFS Programs. ~~in order to facilitate the receiving Contractor's being able to smoothly transition the DME.~~⁶⁸

~~The relinquishing Contractor must provide transitioning members with DME for up to 15 days after the transition date or until the receiving Contractor supplies the service. The receiving Contractor must supply necessary DME within 14 days following the transition date.~~

- ~~a. To facilitate continuity of services, the receiving Contractor is encouraged to~~ must:
- ~~i. Negotiate and/or contract for continued services with the member's current provider, and/or~~
 - ~~ii. Provide instructions and assistance instructions and assistance to new members on how to transfer to a DME provider who is included in the belongs to the new Contractor's provider network.~~
- ~~b. The receiving Contractor must assess medical necessity of DME if equipment was rented by the relinquishing Contractor.~~⁶⁹

2.
Customized DME:

~~For purposes of this Policy, customized DME is defined as equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to~~

⁶⁷ Clarification

⁶⁸ Clarification

⁶⁹ Clarification and conformity.

~~meet the needs of another individual.~~⁷⁰

~~e.a.~~ Customized DME purchased for members by the relinquishing Contractor will remain with the member after the transition. The cost of the equipment is the responsibility of the relinquishing Contractor.

~~d.b.~~ Customized DME ordered by the relinquishing Contractor but delivered after the transition to the receiving Contractor ~~will~~ shall be the financial responsibility of the relinquishing Contractor.

~~e.c.~~ Maintenance contracts for customized DME purchased for members by a relinquishing Contractor will transfer with the member to the new Contractor. Contract payments due after the transition will be the responsibility of the receiving Contractor, if ~~they~~ the receiving Contractor elects to continue the maintenance contract. For FFS Programs, FFS Program rates apply.⁷¹

3. Augmentative Communication Devices (ACDs)

- a. A 90 day trial period is generally necessary to determine if the ACD will be effective for the member, or if it should be replaced with another device.
- b. If a member transitions from ~~one a~~ Contractor ~~to another~~⁷² during the 90 day trial period, one of the following ~~will~~ shall occur:
- c. If the ACD is proven to be effective, the device remains with the member. Payment for the device is the responsibility of the relinquishing Contractor. The cost of any maintenance contract necessary for the ACD ~~becomes~~ shall be the responsibility of the receiving Contractor, if ~~they~~ the receiving Contractor elects to continue the maintenance contract. For FFS Programs, FFS Program rates apply.⁷³ ~~or~~
- d. If the ACD is proven to be ineffective, it is returned to the relinquishing Contractor. The receiving Contractor ~~must~~ shall reassess the member's medical condition and purchase a new device if it is determined to be potentially effective in meeting the member's needs.

NOTE: If the member has had the ACD for more than a 90

⁷⁰ Added definition for clarification.

⁷¹ Clarification and conformity.

⁷² Clarification

⁷³ Clarification

day trial period, the Customized DME process in section 2 above applies.

~~Refer to Chapter 300 of this Manual for additional information regarding DME.~~

K. MEDICAL RECORDS TRANSFER DURING TRANSITION

~~Medical records must be forwarded when there is significant consequence to current treatment, or⁷⁴ if requested by the receiving Primary Care Provider (PCP) or specialty provider. The cost of copying and transmitting of the medical record information specified in this Policy will be the responsibility of the relinquishing PCP unless otherwise noted.⁷⁵~~

To ensure continuity of member care during the time of enrollment change, Contractors ~~must shall have the following procedures in place to ensure timely medical records.~~ Refer to AMPM Chapter 900, Policy 940 for additional information.⁷⁶

~~Procedure to be used by the relinquishing Contractor⁷⁷ PCP to transfer member records to the receiving Contractor PCP.~~

Procedure regarding:

~~The portions of a medical record to copy and forward to the receiving Contractor PCP. The relinquishing PCP must transmit at least those records related to diagnostic tests and determinations, current treatment services, immunizations, hospitalizations with concurrent review data and discharge summaries, medications, current specialist services, behavioral health quarterly summaries and emergency care.~~

~~A defined timeframe for the receipt of medical records by the receiving PCP (i.e., on the date of transfer, after hospital discharge, prior to transfer).⁷⁸~~

~~Relinquishing ALTCS Contractors must ensure copies of the documentation/records noted on the ALTCS ETI form (found in Chapter 1600 of this manual) are sent to the receiving ALTCS Contractor prior to the date of~~

⁷⁵ Information redundant and not needed.

⁷⁶ Clarification

⁷⁷ Conformity

⁷⁸ Requirements are outlined in AMPM Chapter 900, Policy 940 for specificity regarding medical records and communication of clinical information, conformity and clarification.

transition.⁷⁹

~~Maintaining confidentiality of each member's medical records. In accordance with Federal or State laws and Court orders, Contractors must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 C.F.R. 431.300 *et seq.*~~

~~Transfer of other requested medical records, exceeding the requirements of this policy, including resolution of payment for copying and transmitting medical record data.~~

~~Refer to Policy 550 Member Records and Confidentiality of this Chapter, AMPM Chapter 600 Provider Qualifications and Provider Requirements, and AMPM Chapter 900 Quality Management and Performance Improvement Program for additional AHCCCS requirements related to medical records and confidentiality.~~⁸⁰

L. INTER-RBHA AND RBHA – TRBHA TRANSFERS/REFERRALS RESULTING IN OUT OF SERVICE AREA PLACEMENT⁸¹⁸²

~~When The Relinquishing RBHA must coordinate care for individuals who are transitioning from one RBHA to another RBHA or to a TRBHA to receive behavioral health services:~~

- ~~1. a relinquishing~~⁸³ RBHA initiates a referral for placement of an integrated member with SMI or any non-integrated member to ~~another RBHA or~~⁸⁴ a service provider in another RBHA's service area for the purposes of obtaining

⁷⁹ Original suggested language to be placed here, already addressed in prior section, clarification.

⁸⁰ Formatting and clarification.

⁸¹ Header revised to reflect conformity to current practice and clarification.

⁸² Language in Section L originally from DBHS Policy 901 and further revised to align with policy formatting and terminology as well as updated to include current process for retention of member's behavioral health enrollment in the system. Also added reference to new Attachment B 520-2 Out of County Placement Request.

⁸³ Clarification

⁸⁴ Clarification

behavioral health services, the resulting relocation of the member may result in the eligibility source making corresponding changes to a member’s address may change in the PMMIS system. A change of address to another GSA will cause the integrated SMI member to become enrolled with an Acute Care Contractor for physical health services.

- ~~1. The RBHA with which the member is enrolled and who made the referral for the out of area placement must:~~shall take steps to ensure retention of the
2. member’s behavioral health enrollment assignment as well as financial responsibility for behavioral health services for the member during the period the member is placed out of the RBHA’s service area.

- ~~a. The referring RBHA of enrollment is responsible for completing and submitting an Out of Area County Placement Request utilizing Attachment B of this Policy to ensure AHCCCS is aware of and can flag the member as being in an out of area placement. receives the information needed regarding the member’s enrollment.~~

- ~~b. AHCCCS will utilize the submitted documentation to update the member’s record with an indicator that will bypass enrollment information in normal n PMMIS behavioral health enrollment assignment in order to bypass traditional triggers. to bypass. These normal triggers which would otherwise change a member’s behavioral health enrollment assignment due to an out-of-GSA address change, and.~~

- ~~a-c. The referring RBHA of enrollment is responsible for submitting Attachment B in its entirety and for any extension or change to the effective date of placement transfer and/or end date of placement transfer to ensure that the indicator remains in effect only as appropriate implementation of this process.~~

- ~~3. When a member is placed in an out of area placement (The referring RBHA of enrollment shall establish contracts with out-of-area service providers for both physical and behavioral health services and authorize payment for behavioral health services, and.~~

~~Maintain the responsibilities of the behavioral health provider, and~~

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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 the integrated member with SMI to be re-enrolled with the original RBHA as an integrated member, and the RBHA shall provide or arrange for all needed services. The non-integrated member will be reassigned to the RBHA for behavioral health

⁸⁵ Information addressed in “a” above, clarification.

services. The RBHA of enrollment shall provide or arrange for all needed services when the person returns to the service area

5. When a ⁸⁶TRBHA initiates a referral for placement to ⁸⁷a service provider in another TRBHA's service area outside of the TRBHA zip codes 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 PMMIS. a member's address may change in the system. The TRBHA with which the member is enrolled assigned may utilize the steps outlined above to ensure retention of the member's enrollment behavioral health assignment (as well as maintain financial care coordination responsibility for behavioral health services with DFSM) for the member during the period the member is out of the TRBHA's service area.

⁸⁶ Clarification
⁸⁷ Clarification

~~ATTACHMENT A, ENROLLMENT TRANSITION INFORMATION FORM~~

~~[SEE THE AMPM WEBPAGE FOR ATTACHMENT A, OF THIS POLICY](#)~~

OPEN UNTIL 01-07-2017