AmeriHealth Caritas Family of Companies
Medicaid Policy and Procedure

Supersedes:	State-specific ACFC Health Plan versions of this policy	**Policy Number:**	UM.700
Subject:	**Member Transition of Care (Continuity of Care)**		
Department(s):	Utilization Management	**Current Effective Date:**	05/2024
		Last Review Date:	07/2023
		Original Effective Date:	12/2022
		Next Review Date:	05/2025

Applicable Lines of Business:

☒**100**: Keystone First
☒ **500/530/540/550**: AmeriHealth Caritas Pennsylvania
☒ **2100**: AmeriHealth Caritas Louisiana
☒ **2400**: Select Health of South Carolina
☒ **2600**: Blue Cross Complete
☒ **5400/5410**: AmeriHealth Caritas District Of Columbia
☒ **6400:** AmeriHealth Caritas Florida
☒ **7100**: AmeriHealth Caritas Delaware
☒ **7200:** Community HealthChoices (KFCHC, ACPCHC)
☒ **900**: AmeriHealth Caritas New Hampshire
☒ **1200:** AmeriHealth Caritas North Carolina
☒ **7700:** AmeriHealth Caritas Ohio

Scope
This policy applies to the following AmeriHealth Caritas Family of Companies (ACFC) business operations.

Member is defined as enrollee, participant,recipient or beneficiary.

As necessary to comply with local state regulations, the contents of this policy may be copied into a stand-alone document for a specific business operation.

Purpose
To outline the process followed for providing an ongoing source of care appropriate for member-specific needs and designation of an associate and/or care team as primarily responsible for coordinating services accessed by a member who:

- Transitions to ACFC from Medicaid Fee-for-Service, Managed Care Organization/Local Care Management Network (MCO/LCMN), or another Health Plan (HP), or members transitioning out of ACFC to the Medicaid Fee-for-Service program.
- Has an ongoing special condition, as specified in this policy, or are engaged in an active course of treatment with a practitioner or provide, or who is in their 2nd or third trimester of pregnancywho does not participate in the ACFC network.

Policy
ACFC provides continuing coverage of care for members engaged in an active course of treatment with any non-participating practitioner/provider and allows members to directly access a specialist as

appropriate for the member's condition and identified needs. ACFC aims to promote continuity of care in the situations outlined in this policy and those further described in the contract-specific attachments. ACFC's Medicaid program shall provide continuing coverage of care in the following situations:

- For members that are Newly Enrolled and:
    - Transitioning into or out of the ACFC Medicaid program
    - Are pregnant
    - Have a Special Healthcare Condition(s)
    - Receiving Community and Social Support Services
- Provider/practitioner-related transitions such as:
    - Member's transition of care from an out-of-network to an in-network provider
    - Provider terminations

Additionally, ACFC provides timely information for members transitioning out of an ACFC plan to another health plan or newly enrolling from another Health Plan or Medicaid Fee for Service to help ensure continuity of care for each member and minimize the burden on providers during the transition.

Definitions

- N/A

Procedure

A. Newly Enrolled Members

1. ACFC shall honor any written documentation of prior authorization of ongoing covered services for the timeframe defined, by the state regulator, or if not defined, ACFC will honor for up to ninety (90) days after the effective date of enrollment (unless otherwise specified in the state specific requirements stated in the addenda), or until the member's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the member's treatment plan, whichever comes first.[1]

2. Upon initial enrollment into an ACFC Medicaid program, the member, member's appointed representative, or the member's provider may request continuity of care services electronically, by telephone, fax, or written request. Clinical information documenting the medically necessary covered services within the last six months will be requested by UM if not provided by the member, member's representative and/or provider. ACFC will ask the member to authorize release of their clinical records to the new PCP or other appropriate provider and shall assist by requesting those records from the member's previous providers. Once received, UM will review, assess, and coordinate services as needed if it is determined that the member may suffer serious detriment or be at risk for hospitalization or institutionalization.

3. If the member is in any inpatient hospital setting on the date of enrollment, ACFC will follow the state guidelines for coverage related to enrollment during hospitalization. ACFC will be responsible for all care from the date of discharge forward.

[1] See DC Medicaid Addendum for additional market-specific criteria

B. Newly Enrolled Pregnant Women

1. If the member is pregnant upon enrollment to the ACFC plan and in the 2nd or 3rd trimester, ACFC will cover treatment by the member's existing care team through the duration of the member's pregnancy, including the postpartum care period (60 days of postpartum care) [2] unless otherwise specified in the state specific requirements.

C. Newly Enrolled Members with Special Healthcare Conditions

1. Members who have special health care needs[3] are Medicaid or CHIP eligible and are receiving medically necessary covered services, the day before ACFC enrollment, ACFC shall provide continuation/coordination of services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. ACFC may require prior authorization for continuation of the services beyond thirty (30) calendar days; however ACFC is prohibited from denying authorizations solely on the basis that the provider is a non-contracted providers.

D. Member Receiving Community and Social Support Services

1. ACFC aims to strengthen coordination and continuity of care across clinical and nonclinical settings to improve transitions when members are newly enrolled with the organization and/or impacted by changes to practitioners/providers rendering care or services to them. ACFC will coordinate services for members receiving services provided from community and social support providers which include but are not limited to recovery counseling, nonclinical social assistance, residential support, and other programs addressing social determinants of health.

E. Member Transition to Network Provider

1. ACFC will prioritize the member's transition of care from an out-of-network to an in-network provider. Considerations will include ensuring that the member's condition has stabilized and that there is no interruption to authorized, covered services.

   If the member chooses to change to a network provider or if quality concerns are identified with the previously authorized provider, ACFC will facilitate the transition of services to an in-network provider.

F. Practitioner/Provider Terminations

1. When a participating practitioner/provider terminates from the ACFC network not for cause, ACFC will continue to provide medically necessary services from the terminated provider through the current period of active treatment or up to ninety (90) days not to exceed 6 months, whichever is less from the effective date of the provider termination. ACFC will provide continuation of care through the postpartum period for members in their second or third trimester of pregnancy. If ACFC

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[2] See FL and NC Medicaid Addenda for variations in the applicable timeline for continuity of care during pregnancy
[3] See state-specific Addendum for list of special healthcare conditions

timeframes are not in alignment with state specific contractual or regulatory requirements the state specific requirements will be followed. These requests will continue to be reviewed for medical necessity. Circumstances considered not for cause include:

- The provider chooses to end participation in the ACFC network; or
- ACFC elects to terminate the provider contract without cause; or
- The provider's contract expires and is not renewed

In situations where the provider termination is related to quality of care or program integrity, ACFC's Care Management department staff will assist the member to identify and transition to a new provider that can meet the member's needs.

Related Policies

See also - Policy UM.001 *Glossary of Terms*
See also - Policy UM.903 *Glossary of Abbreviations*
See also - Policy 168.235 *HIPAA Privacy Definitions*
See also - Policy 168.200 *Authorization to Use or Disclose PHI*
See also - Policy 168.212 *Facsimile Machines and Transmission of Protected Health Information*
See also - Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data*
See also - Policy 168.227 *Use and Disclosure of Protected Health Information without Member Consent or Authorization*
See also - Policy 591.001 *Records Retention Policy & Schedule*

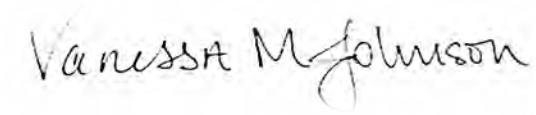
Source Documents & References

- PHL Title 42 CFR 438.208(b)(2)(iv)
- 29 U.S. Code § 1185g - Continuity of Care
- MCO Standards for Accreditation - National Committee for Quality Assurance (NCQA), Utilization Management Standards, UM 1A, Factors 5, 6

Attachments

N/A

Approved by:



Vanessa Johnson
Vice President, Utilization Management Operations
Date: June 14, 2024

Lenaye Lawyer

Vice President, Medical Affairs
Date: June 14, 2024

Revision Date	Revision
7/2023	Annual review: Updated name of policy from Continuity of Care to **Member Transition of Care (Continuity of Care)** Removed definitions and added to Glossary of Terms – UM.001 policy.
5/9/2024	Annual Review. Added: Under heading "Purpose", 2nd bullet - "…or who is in their 2nd or third trimester of pregnancy…" A.1 – updated 60 calendar days to 90 calendar days F.1 – updated first sentence to accurately state requirement. Addition - "ACFC will provide continuation of care through the postpartum period for members in their second or third trimester of pregnancy." F.1, added another bullet to state – "ACFC elects to terminate the provider contract without cause; or"

AmeriHealth Caritas Family of Companies

Medicaid Policy Addendum

Territory: Louisiana

Addendum Number: UM-A.700.LA

Subject: Member Transition of Care (Continuity of Care)

Department(s): Utilization Management

Current Effective Date: 11/12/2024

Last Review Date: 11/24/2024

Original Effective Date: 11/13/2023

Next Review Date: 11/2025

POLICY

Service/Program	ACLA State Distinction	Reference/Source
New Enrollees	• Enrollees receiving medically necessary covered services the day before becoming an ACLA Enrollee: o Can continue to receive medically necessary services for the first 30 days of enrollment without the need for a medical necessity review regardless if services are being provided by a participating or non-participating ACLA Practitioner/Provider • Within the first 30 days ACLA will not deny authorization solely on the basis that the Practitioner/Provider is not a participating ACLA Practitioner/Provider. • After 30 calendar days: o Prior authorization requirements apply for those services identified as requiring prior authorization o ACLA will continue to provide coverage for services determined to be medically necessary for an additional thirty (30) calendar days or until the Enrollee may be reasonably transferred without disruption, whichever is less.	*2.12.7- Service Authorization Requirements for New Enrollees*
Newly Enrolled Pregnant Women	• Who are receiving medically necessary covered services in addition to, or other than, prenatal	*2.12.7- Service Authorization*

Service/Program	ACLA State Distinction	Reference/Source
	services (see below for newly enrolled Enrollees receiving only prenatal services) at the time of becoming an ACLA Enrollee, ACLA will be responsible for the costs of continuation of such medically necessary services, without regard to whether such services are being provided by network or non-Network Provider. ACLA will provide continuation of such services up to ninety (90) calendar days or until the Enrollee may be reasonably transferred without disruption, whichever is less. • ACLA may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, ACLA will not deny authorization solely on the basis that the Provider being an out-of-Network Provider within the first 30 calendar days. • ACLA shall ensure that the Enrollee is held harmless by the provider for the costs of the above medically necessary MCO Covered Services. • Enrollees in their 1st Trimester: o can continue to receive such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without prior authorization and without regard to whether such services are being provided by a participating or non- participating ACLA Practitioner/Provider until such time as ACLA can reasonably transfer the Enrollee to a participating ACLA Practitioner/Provider without impeding delivery that might be harmful to the Enrollee's health. • Enrollees in their 2nd or 3rd Trimester: o can continue to receive services from their prenatal care Practitioner/Provider (whether a participating or non-participating ACLA Practitioner/Provider) for sixty (60) calendar days postpartum, provided the Enrollee is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the postpartum period.	*Requirements for New Enrollees*

Service/Program	ACLA State Distinction	Reference/Source
New Enrollees Receiving Medicaid Covered Durable Medical Equipment (DME), Prosthetics, Orthotics, and Certain Supplies at Time of Enrollment	• If services were provided by another MCO or Medicaid fee-for-service (FFS) at the time of Enrollment Enrollees can continue to receive these services, without prior authorization and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. • ACLA will continue to provide coverage for services for up to ninety (90) calendar days or until the enrollee may be reasonably transferred to a participating provider without disruption, whichever is less. • ACLA will honor any prior authorization for durable medical equipment, prosthetics, orthotics, and certain supplies issued while the Enrollee was enrolled in another MCO or Medicaid fee-for-service for a period of ninety (90) calendar days after the Enrollee's enrollment into ACLA.	*2.12.7.5- DME, Prosthetics, Orthotics, and Certain Supplies*
Transition To/From Another MCO or Medicaid FFS	• ACLA will provide active assistance to enrollees when transitioning to/from another MCO or to Medicaid FFS in accordance with a transition of care policy that ensures continued access to services during the transition, when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. To include the following: o The Enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for 30 days if that provider is not in the ACLA's network. o Coordinating care with the relinquishing MCO so services are not interrupted o Arranging for continuity of necessary care by making referrals to appropriate providers of services that are in network; o Ensure timely notification to the receiving MCO regarding pertinent information related to any health needs of transitioning Enrollees. o ACLA fully and timely complies with requests for historical utilization data from the new MCO or Medicaid FFS in	*2.8.3- Transitioning Between MCOs or FFS*

Service/Program	ACLA State Distinction	Reference/Source
	compliance with Federal and State laws, regulations, rules, policies, procedures, and manuals. The Transition report form LDH is received and reviewed monthly to gather and provide appropriate medical records and case management files of the transitioning member to the accepting MCO. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing contractor. o ACLA shall be consistent with federal and state law and the enrollee's new provider(s) are able to obtain copies of the Enrollee's health records, as appropriate by contacting the UM department. o ACLA shall coordinate any other necessary procedures as specified by LDH in writing to ensure continued access to services to prevent serious detriment to the Enrollee's health or reduce the risk of hospitalization or institutionalization.	
New Enrollees Hospitalized at time of transfer	• If hospitalized at time of transfer between MCO: o the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the Enrollee is discharged. The receiving MCO is responsible for all other care. o In the event that the relinquishing MCO's contract is terminated prior to the Enrollee's discharge, responsibility for the remainder of the hospital charges shall revert to the receiving MCO, effective at 12:01 a.m. on the Calendar Day after the relinquishing MCO's contract ends. • Special consideration to be given to, but not limited to, the following: o Enrollees with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition; o Enrollees who have received prior	*2.8.3.4-2.8.3.5: Transitioning Between MCOs or FFS*

Service/Program	ACLA State Distinction	Reference/Source
	authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-are specialty services; o Enrollees who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels or Enrollees who were born prematurely; and o Enrollees with significant medical conditions such as a high-risk pregnancy or pregnancy within the last thirty (30) Calendar Days, the need for organ or tissue transplantation, or chronic illness resulting in hospitalization.	
Current Enrollees receiving care from a Terminated Practitioner/Provider	• May continue an ongoing course of treatment (defined as treatment for a chronic or acute medical condition; behavioral health condition; or life-threatening illness) with a Practitioner/Provider whose contract is terminated with ACLA (either by ACLA or by the Practitioner) for up to ninety (90) calendar days from the effective date of the termination. Including: o an ongoing course of treatment with a non-participating Obstetrician (OB) or Midwife through the completion of post-partum care related to the delivery. o Indian Enrollees who are enrolled and are eligible to receive services from an IHCP Primary Care Provider participating as a network provider, and has the right to the following: ▪ That IHCP as his or her PCP, as long as that provider has capacity to provide the services. ▪ To obtain services covered under the contract from out-of-network providers where timely access to covered services cannot be ensured by ACLA. ▪ An out-of-network IHCP is allowed to refer an Indian member to a network provider. • Coverage for the continuation of an ongoing course of treatment will not be provided in the following circumstances:	*2.8.1.4.9- Continuity of Care and Care Transitions* *2.9.18- Prenatal Care Services* *2.9.26- Indian Health Care Providers (IHCP)*

Service/Program	ACLA State Distinction	Reference/Source
	o The Practitioner/Provider contract was terminated by ACLA as the result of a professional review action (quality of care issue) o The Practitioner/Provider is unwilling to continue to treat the member or accept ACLA's payment or other terms	
Behavioral Health	• ACLA shall collaborate with Office of Juvenile Justice (OJJ), Department of Children and Family Services (DCFS), and DOE to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated; • Collaborate with nursing facilities, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IIDs), hospitals, residential facilities and inpatient facilities to coordinate aftercare planning prior to discharge and transition of Enrollees for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers; • Collaborate with the Department of Corrections and local criminal justice systems in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services for Enrollees, including referral to community providers, prior to reentry into the community including, but not limited to, Enrollees in the Louisiana Medicaid Program pre-release program. • Referrals shall be made for Enrollees to coordinate care with behavioral health and primary care providers and agencies that promote continuity of care. • ACLA shall be responsible for the coordination and continuity of care of health care services for all Enrollees consistent with 42 CFR §438.208. In addition, ACLA shall be responsible for coordinating with LDH, including the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, to ensure integrated support across behavioral	*2.8.2- Continuity of Care and Care Transitions for Behavioral Health*

Service/Program	ACLA State Distinction	Reference/Source
	• health services and long-term supports and services. • ACLA shall facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration include: o Mental illness and addiction are health care issues and shall be integrated into a comprehensive physical and behavioral health care system that includes primary care settings; o As care is provided, both illness shall be understood, identified, and treated as primary conditions; o The system of care shall be accessible and comprehensive, and shall fully integrate an array of prevention and treatment services for all age groups. It shall be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; and o Relevant clinical information is accessible to both the primary care and behavioral health providers consistent with Federal and State laws, regulations, rules, policies, and other applicable standards of medical record confidentiality and the protection of patient privacy	
	• For SBHS, ACLA shall have a process by which ACLA's staff may connect the Enrollee to another service or service provider (e.g., locating a provider, ensuring the provider has availability, and/or securing an appointment), if appropriate, to ensure Enrollee continuity of care	2.12.3.6.5- General Service Authorization Requirement

PROCEDURE

Service/Program	ACLA State Distinction	Reference/Source
New members with non-participating practitioners or providers- Transition Report	• The UM staff will review the transition report from LDH monthly to determine if the Enrollee is transitioning from another MCO. • Once identified as a transitioning Enrollee a request for information on all open prior authorizations will be sent to the relinquishing MCO. The UM staff will enter an authorization for a request for continuation of services meeting the above guidelines into the ACLA authorization system for the continuation of services time period	

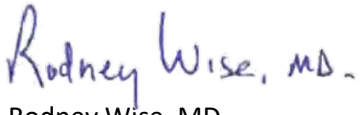
Service/Program	ACLA State Distinction	Reference/Source
	outlined above. • ACLA will in turn provide the medical information to an accepting MCO or Medicaid FFS upon request for Enrollees transitioning off the plan in the same manner.	
Current Enrollees when a practitioner/provider terminating from the plan	• When Provider Network Management staff become aware that a practitioner's/provider's contract is or will be terminated and continuity of care is available through this policy, an ad-hoc report is run to identify all Enrollees who received care within the last 18 months from the practitioner/provider whose contract is terminating and the corresponding head of household, where applicable. For terminating PCPs, a panel report is run, listing all current active Enrollees and the corresponding head of household. • The Enrollee is notified by letter of the following information within fifteen (15) calendar days of the receipt of the termination notice from the provider: o The terminated practitioner/provider and the effective date of termination o The Enrollee's ability to continue services with the terminating practitioner/provider and how to access such services o For terminating PCPs, the letter also identifies the name, address and phone number of the new PCP assigned by the plan; a statement explaining the PCP assignment process; and notification that the Enrollee may select a different PCP by calling Enrollee Services. o For terminating specialty practitioners, the letter contains a statement advising the Enrollee to contact their PCP to discuss any required ongoing medical needs, including transition to another participating specialist • If the plan is not the primary insurer for the Enrollee, the Enrollee may choose to stay with the terminated practitioner/provider. All care/services from nonparticipating practitioners or providers require prior authorization. (See ACLA Policy	

Service/Program	ACLA State Distinction	Reference/Source
	#UM.904L – Authorization for Out-of-Network Practitioners and Providers) ACLA's authorization requirement may be waived if the primary insurance is Medicare. • Emergency/Urgent care services do not require a prior authorization of services for participating or non-participating providers and is accessible for transitioning Enrollees.	

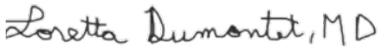
Reference:

Louisiana Medicaid Managed Care Organization Attachment A: Model Contract

Signatures



Rodney Wise, MD
Market Chief Medical Officer (CMO) Signature
Date



Loretta Dumontet, MD
Behavioral Health Medical Director
Date

Revision Date	Revision
10/2023	• Transitioned policy from 153.706 Continuity of Care plan policy to corporate base policy UM.700 Member Transition of Care (Continuity of Care) with state specific addendum to meet plan requirements. • Within the first 30 days ACLA will not deny authorization solely on the basis that the Practitioner/Provider is not a participating ACLA Practitioner/Provider. • New Enrollee Hospitalized at Time of Transfer added: In the event that the relinquishing MCO's contract is terminated prior to the Enrollee's discharge, responsibility for the responsibility for the remainder of the hospital charges shall revert to the receiving MCO, effective at 12:01 a.m. on the Calendar Day after the relinquishing MCO's contract ends.

	• Current Enrollees when a Practitioner/Provider Terminating from the Plan: Removed 10 business days timeframe PCP letter should be mailed. Added ad-hoc report is run to identify Enrollees who received care within the last 18 months when PNM is aware that a Practitioner/provider's contract is terminated.
10/22/2024	• Added: ACLA must have a process in place to ensure continuity of care for SBHS.