State Health Reform Assistance Network
Charting the Road to Coverage

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Creating Seamless Coverage Transitions Between Medicaid and the Exchanges

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IN BRIEF

Under health reform, Medicaid will expand in 2014 to cover an additional 16 to 20 million beneficiaries. This population will include a significant percentage of childless adults with urgent and complex health care needs, who are likely to shift between subsidy programs over time. This brief draws from current programs that have dealt with this challenge successfully, with the hope that their experience will help guide seamless coverage transitions between Medicaid managed care organizations and qualified health plans in the exchanges. A companion chart includes excerpts of sample contract language related to coverage transitions in existing programs.

INTRODUCTION

The 2014 expansion of Medicaid under the Affordable Care Act (ACA) will cover 16 to 20 million new beneficiaries, most of whom will be childless adults with incomes below 138 percent of the federal poverty level (FPL). Many of these individuals are likely to have complex health care needs and pent-up demand for care.[1] Due to fluctuations in income, this population is also likely to "churn" between existing Medicaid programs, the new Medicaid expansion, subsidized exchange qualified health plans (QHPs), and possibly state-run basic health plans, creating a heightened need for seamless coverage transitions across state health care programs.[2] While the Affordable Care Act (ACA) offers numerous opportunities to stabilize coverage for beneficiaries as their incomes rise and fall, the path is far less clear for creating continuous care.

This brief examines how seamless coverage transitions can be supported through policies designed to provide continuous care for individuals moving between health insurance products, plans, and providers. It reviews lessons from: (1) existing exchange programs in Massachusetts; (2) transition coverage policies within

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State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

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The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

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[1] S.A. Somers, A. Hamblin, J.M. Verdier, and V.L.H. Byrd. "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States." Center for Health Care Strategies, August 2010.
[2] S. Rosenbaum, S.A. Somers, and S. McMahon. "Strategies for Building Seamless Health Systems for Low-Income Populations." Center for Health Care Strategies, February 2012.

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Tennessee's proposed exchange model; and (3) current transition practices between Medicaid managed care organizations (MCOs) and other programs. These models offer insights to aid states in developing coverage linkages between current public programs, programs for the future Medicaid expansion population, and options provided by proposed insurance exchanges. A companion chart summarizes existing coverage transition practices from various sources, including: (1) state Medicaid managed care contracts; (2) the National Committee for Quality Assurance (NCQA); and (3) Medicare Part D. Sample contractual language related to coverage transitions is also provided. This preliminary review is not intended to be exhaustive; rather, it is meant to raise considerations for states as they develop coverage approaches between Medicaid and a state or federal exchange.

This analysis stems from work done to help the state of Maryland assess contractual requirements related to coverage transitions. As of early April 2012, the Maryland General Assembly was finalizing a bill to establish its health insurance exchange. Both the House and Senate versions of the bill include a provision that requires the state's exchange to address coverage transitions across Medicaid and the future QHPs within the exchange. Although originally developed as a resource for Maryland, this brief offers value to all states in establishing provisions to preserve care continuity across health insurance coverage programs.

UNDERSTANDING THE IMPORTANCE OF COVERAGE TRANSITIONS

Within a six-month timeframe, it is projected that more than 35 percent of all adults with family incomes below 200 percent of FPL will experience a shift in eligibility from Medicaid to coverage provided by an insurance exchange. Additionally, within a year, an estimated 28 million individuals will transition from coverage through an exchange to Medicaid.[3] For the population that will churn between Medicaid and QHPs, strategically designed coverage transitions can help ensure continuity of care with current providers or health care delivery systems. Smooth coverage transitions are particularly crucial to minimize disruptions in services for individuals who are in a prescribed course of treatment, e.g., radiation or chemotherapy, as well as those with special health care needs. This latter population includes those who have serious and chronic physical, developmental, and/or behavioral health conditions requiring medically necessary health and related services beyond those required by the typical beneficiary. Some states also include pregnant women, people who are hospitalized at time of transition, and individuals who received prior authorization for services from the *relinquishing* contractor in this higher-need subset of patients who require a more intense level of services over a short period of time. In other states, including Arizona, a beneficiary is considered to have special health care needs if a medical condition lasts, or is expected to last, one year or longer and requires ongoing care by a specialty provider.

In establishing the exchanges, states need to develop policies on how to transition coverage for individuals in a current course of treatment as well as for special needs populations as they churn beyond Medicaid into the exchange and vice versa. Of particular interest is how provider networks will be developed in QHPs to ensure access to essential community providers, such as federally qualified health centers (FQHC) or the Indian Health Service (IHS). Many low-income individuals with special health care needs will want to continue to see their existing providers, including safety-net providers, even as they move to a commercial network on the exchange. This raises a critical continuity of care issue. Indeed, recently issued regulations require QHPs to include in their provider networks a "sufficient number and geographic distribution of Essential Community Providers (ECPs) to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the QHP service areas," yet do not mandate that all ECPs be included as enrolled providers.[4] The regulation also allows flexibility for QHPs in how safety net providers are reimbursed. Specifically, the regulation does not require QHPs to contract with ECPs that refuse to accept "generally applicable payment rates."[5] However, the regulation requires QHPs to pay FQHCs the relevant Medicaid prospective payment system (PPS) rate. Alternatively, QHPs may pay a mutually agreed-upon rate to the FQHC provided that such rate is at least equal to the QHP issuer's generally applicable rate.[6]

[3] B. D. Somers and S. Rosenbaum. "Issues In Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." *Health Affairs*, February 2011, vol. 30 no. 2.
[4] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers 77 FR 18470, page 18470.
[5] Ibid.
[6] Ibid.

Given the new federal contracting requirements for QHPs, states will need to examine policies that ensure provider continuity of care. In addition, beneficiaries may have an ongoing treatment cycle with a particular drug, e.g., a chemotherapy drug that may not be on the formularies held by the individual's current health plan. To address such instances, states will need policies to ensure temporary access to drugs until prescriptions can be changed to conform to the receiving plan.

Transition of care issues may also be particularly important for individuals with jail involvement, whose eligibility may fluctuate between Medicaid and the exchanges following their incarceration and/or release. Jail-involved individuals have high rates of mental illness and substance use disorders, making coverage transitions particularly relevant for assuring them continued access to community-based behavioral health treatment.[7] Accordingly, states may want to consider policies such as those described below to ensure that jail-involved individuals with behavioral health needs maintain access to providers and ongoing courses of treatment during these coverage transitions.

MEDICAID AND THE EXCHANGES

To understand how contracting provisions can support coverage transitions between Medicaid and the exchange, it is helpful to look at requirements in states with operational health insurance exchanges. Currently Massachusetts and Utah have health insurance exchanges. While cognizant of the need for seamless transitions between health insurance program options, Utah has not yet developed coverage transition requirements.

Massachusetts, on the other hand, has extensive contract language to help guide MCO coverage transitions between Medicaid and the state's Health Connector program. The state's MCO contractors must perform readiness reviews prior to enrolling new beneficiaries, then take steps to minimize disruptions in care and ensure uninterrupted access to medically necessary services. At a minimum, Massachusetts' MCO contractors must provide transition plans for the following new enrollee subsets: (1) pregnant women; (2) individuals with significant health care needs or complex medical conditions; (3) people receiving ongoing services or who are hospitalized at time of transition; and (4) individuals who received prior authorization for services from the *relinquishing* MCO contractor. For individuals in each of these population subsets, Massachusetts requires *receiving* MCOs to complete a transition plan that is tailored to the new enrollee's specific health care needs. An analysis of 2006 data found that although there are gaps in coverage, Massachusetts' continuity ratio—the portion of the year during which the average Massachusetts Medicaid enrollee is continuously enrolled—is 82 percent, higher than the national average of 78 percent and among the highest in the nation.[8]

Moving forward with its exchange planning, Tennessee is proposing a policy to the Centers for Medicare & Medicaid Services (CMS) that allows family members who are enrolled in different Medicaid and exchange health insurance programs to receive coverage through a common carrier or provider network. This option would apply to families regardless of their eligibility status or the delivery system offered. In addition, Tennessee has requested CMS permission to provide continuity for beneficiaries by allowing them to retain coverage through the same insurer and provider network if their eligibility status changes (e.g., from Medicaid to premium tax credits or vice versa). Tennessee's pending proposal to CMS would allow the state's exchange to limit eligibility for bridge products to individuals who have a dependent in their immediate family who is enrolled in Medicaid or CHIP or has been enrolled in either program within the last six or 12 months.[9] As a result, the bridge product may be available only to a subset of individuals of a particular age in a given rating area (depending on the issuer's preference).

EXISTING MEDICAID BEST PRACTICES

To facilitate transitions between Medicaid MCOs, several states include coverage transition provisions in their MCO contracts that protect populations receiving certain types of care (see *Managing Coverage Transitions: State and National Models* appendix chart). In general, *receiving* MCOs are held responsible for continuing care previously provided by the

[7] A. Hamblin, S.A. Somers, S. Neese-Todd, and R. Mahadevan. "Medicaid and Criminal Justice: The Need for Cross-System Collaboration Post Health Care Reform." Community Oriented Correctional Health Services, January 2011.
[8] R. Seifert, G. Kirk, and M. Oakes. "Enrollment and Disenrollment in MassHealth and Commonwealth Care." Center for Health Law and Economics and Massachusetts Medicaid Policy Institute, April 2010.
[9] "Tennessee Bridge Option: One Family, One Card Across Time" TennCare. http://www.tn.gov/nationalhealthreform/forms/onefamily.pdf

relinquishing payer. Conversely, in some instances, the *receiving* MCO might allow transitioning beneficiaries to continue to obtain care from their previous provider for a specific timeframe. In addition, some states mandate that *relinquishing* MCOs be held financially responsible for provision of care to enrollees during the transition period. Specific transitional care issues addressed in state MCO contract language include:

1. Pregnancy;
2. Certain dental care, such as orthodontia;
3. Hospitalizations;
4. Transplants;
5. Chemotherapy, radiation therapy, and dialysis;
6. Individuals with ongoing needs such as durable medical equipment, home health services, or prescription medications;
7. Individuals with prior authorizations for procedures; and
8. Behavioral health and chemical dependency services.

In some cases, state contracts "protect" individuals receiving certain therapies by allowing them to continue treatment with current and non-participating providers. Many states require that both *receiving* and *relinquishing* MCOs coordinate coverage of individuals who are transitioning and jointly develop a transition plan to provide services within a defined timeframe, ranging anywhere from 90 to 120 days. Although timeframes for coordination of services are not always specified, MCO contractors are generally expected to coordinate transitional services, including necessary phase-in and phase-out strategies for individuals receiving critical care.

In addition to ensuring seamless coverage transitions through contracting, states can use eligibility tools to keep individuals covered during transitional periods. The eligibility regulations released by CMS in March 2012 note that while states are not required to extend Medicaid eligibility through the end of the month in which an individual is no longer eligible, they are encouraged to do so. To reduce coverage gaps as individuals transition between Medicaid and QHPs, CMS authorizes federal funding to states that extend coverage to the end of the month at the applicable match rate for that extended period.[10]

While Massachusetts is currently the only exchange-to-Medicaid example, the most longstanding examples of transition policies for individuals with special health care needs can be found in existing state requirements for coverage transitions between Medicaid and expansion populations as well as between Medicaid MCOs. States that have existing low-cost health insurance programs offer valuable guidance on how to facilitate smooth coverage transitions for beneficiaries. New Mexico's State Coverage Insurance (SCI) program provides an example that demonstrates how transitions can be handled between Medicaid programs and the future Medicaid expansion population. When women who are covered under SCI become pregnant, they are allowed to stay on SCI and are able to retain the same MCO and providers.[11] Upon birth, the infant is screened and enrolled into Medicaid or SCHIP and is assigned to the mother's MCO. In this way, the mother and baby are able to keep the same MCO and provider throughout this process. New Mexico's SCI program also carefully coordinates necessary coverage transitions for individuals who are transplant candidates. In order to keep SCI affordable to small businesses, the program was designed with a limited benefit package. If someone covered by SCI needs a transplant, the SCI benefit package will not address all of their needs. Thus, once a beneficiary is identified as a transplant candidate, the individual is transitioned into the state's high-risk option, the New Mexico Medical Insurance Pool, so that transplant-related care can continue seamlessly.

New York also offers an existing model for coverage transitions between traditional Medicaid and expansion programs—via a waiver or other Medicaid State Plan option. Because New York has multiple waiver programs allowing the state to expand coverage broadly to parents, children, and individuals with complex needs, the state has specific transition requirements in its health plan contracts to address the care needs of beneficiaries.[12] These contractual obligations balance the needs of the beneficiary with the health plan's need to exercise its care manager role. For example, the contract addresses transitions for

[10] CMS-2349-F, "CMS Medicaid and CHIP Eligibility Changes Under the Affordable Care Act of 2010." The regulations are effective 60 days after publication in the Federal Register. See https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-program-eligiblity-changes-under-the-affordable-care-act-of-2010.
[11] Social Services, State Coverage Insurance, Member Transition of Care, Section 8.306.16.9 New Mexico Administrative Code.
[12] New York State Department of Health Office of Health Insurance Programs, Division of Managed Care. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract. August 1, 2011.

individuals moving between Medicaid managed care and Family Health Plus—the state's insurance program for adults with income too high for Medicaid eligibility. In such cases, a new enrollee with an existing provider who is not within the new plan's provider network is able to continue an ongoing course of treatment by their non-participating provider for up to 60 days from enrollment. In addition, New York's health plan contracts require transitional care for new enrollees undergoing treatment with a participating provider until the health plan's approved treatment plan is in place.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE COVERAGE TRANSITION STANDARDS

The NCQA has established coverage transition standards for Medicaid and private market MCOs that must be met in order for plans to receive NCQA accreditation.[13] Many states require accreditation to license MCOs, and in many cases, NCQA accreditation fulfills state MCO licensing requirements. However, the extent to which NCQA accreditation meets state requirements varies from state to state. NCQA's standards focus on quality improvement and continuity of care in transitions between managed care plans for enrollees with specific conditions. For example, the NCQA standards require plans to allow pregnant women in their second or third trimester whose practitioners are discontinued from a network to obtain care from their previous practitioner through the post-partum period. NCQA standards also specify that individuals undergoing active treatment for a chronic or acute medical condition should be allowed to continue prescribed treatment for a defined period of time in the event that coverage changes. An active course of treatment, e.g., for cancer, typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol. A discontinuation of such treatment could worsen health outcomes.

MEDICARE PART D CARE TRANSITION REQUIREMENTS

Medicare established a transition process for all Part D plans to ensure continuity of care for eligible individuals. Plans must ensure that new members, newly eligible beneficiaries, individuals transitioning from one Part D plan to another, and individuals in long-term care facilities have access to non-formulary medications during their first 90 days in a plan. If medically necessary, the transition period may be extended beyond 90 days. Plans are expected to provide transition fills of non-formulary prescriptions and a written transition notice to enrollees. CMS also requires that plan sponsors ensure that reasonable efforts are made to notify prescribers of enrollees who receive a transition notice after a temporary fill. In addition, plan sponsors are expected to determine the best way to expedite transitions to formulary drugs for enrollees who change treatment settings due to changes in level of care.[14]

POTENTIAL CONTRACTUAL AND TECHNOLOGY SOLUTIONS TO MANAGE COVERAGE TRANSITIONS

State Medicaid agencies may wish to consider developing contractual requirements that call for direct transfer of clinical information to facilitate care coordination between health plans in the post-exchange environment. Such electronic transfer capabilities were envisioned for the statewide Health Information Exchanges, as detailed in the ACA. Health plans could potentially share information to facilitate care coordination for members transitioning to a new health plan. The Office of the National Coordinator for Health Information Technology (ONC) has started the Direct Project, an initiative to develop a secure, scalable, standards-based mechanism for encrypted data transfer of health information directly to payers, providers, and governmental entities over the Internet. Pilot projects in nine states—California, Connecticut, Minnesota, Missouri, New York, Oregon, Rhode Island, Tennessee, and Texas—are currently underway.[15] This project, along with other state-initiated efforts, can support sharing of the following types of secure health information between exchange plans and Medicaid plans:

- Chronic disease diagnoses;
- Emergency room visits with diagnosis;
- Hospital admissions with admitting diagnosis;
- Prescription drug utilization; and

[13] National Committee for Quality Assurance. Standards and Guidelines for the Accreditation of Health Plans. 2011

[14] Medicare Prescription Drug Benefit Manual: Chapter 6 Part D Drugs and Formulary requirements, Section 30.4 Transition. CMS website; available at http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

[15] Office of the National Health Coordinator. "ONC announces launch of "Direct Project" Pilots". http://www.hhs.gov/news/press/2011pres/01/20110202a.html.

- Current open care authorizations.

Electronic information transfer requirements could be placed on contractors when members moved to another Medicaid plan or to a commercial exchange plan, to facilitate care coordination.

CONCLUSION

With the implementation of health reform, up to 20 million Americans will be eligible for Medicaid in 2014. A majority of these newly eligible individuals are likely to churn on and off Medicaid rolls based on irregular and unpredictable income status, and many are also likely to have chronic and unmet health care needs. Establishing policies to support effective coverage transitions is an important step in ensuring seamless delivery of services across publicly subsidized health insurance options.

Smooth transitions across coverage options will help minimize disruptions in care and promote high-quality and consistent services for beneficiaries. States exploring strategies to address coverage transitions can look to Massachusetts, to existing state MCO contract language, and to NCQA standards for insights on managing shifts in eligibility across Medicaid, the basic health plan option, and the exchange.

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Managing Coverage Transitions: State and National Models (effective April 2012)				
States/ Agencies	**General**	**Special Populations: Maternity Care**	**Special Populations: Chronic or Acute Medical Conditions**	**Hospital Stays**
NCQA	NCQA requires transition of care standards for certain conditions.	Members in their second or third trimester of pregnancy have access to their discontinued practitioners (practitioners who are no longer contracting with the MCO) through the post-partum period.	Enrollees undergoing active treatment for a chronic or acute medical condition have access to their discontinued practitioners (practitioners who are no longer contracting with the MCO) through the current active treatment period or for up to 90 calendar days, whichever is shorter.	
Medicare Part D Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4	All Part D sponsors must have a transition process to ensure that newly enrolled members, and other individuals described below, have access to non-formulary medications during their first 90 days in a plan. (For transition purposes, formulary drugs that are subject to prior authorization or step therapy are treated as non-formulary drugs.) The transition process applies to: 1. New members who enroll during the annual coordinated election period (or, depending upon the plan's declared transition policy, current enrollees affected by a formulary change from one contract year to the next); 2. Newly eligible Medicare enrollees who previously had other coverage; 3. Individuals who transition from one Part D plan to another during the year (as through a Special Enrollment Period); and 4. Enrollees in long-term care (LTC) facilities. The transition process requires Part D plans to allow a one-time temporary supply of a non-			

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	formulary drug, during which time the member, his/her physician, and the plan can work out an appropriate change to another drug or start an exception request to obtain the non-formulary drug. The plan must provide a written notice to all members who receive a transition fill within three business days of the temporary fill. For members living in the community, the temporary supply is a one-time fill for at least 30 days (unless the script is written for fewer days). For members living in LTC facilities, the temporary supply may be for up to 31 days, and may be renewed as necessary during the 90-day transition period. Depending on the individual's circumstances, the transition period may be extended beyond 90 days.			
Maryland	1. Health Choice regulations require Medicaid MCOs to pay for certain services without any requirement of referral by the PCP or MCO when the enrollee accesses the service through an out-of-network provider. 2. In general, enrollment brokers and providers are responsible for care continuity during transitions. There is no language requiring care coordination between MCOs and commercial carriers.			
Arizona http://www.azahccs.gov/commercial/Purchasing/contracts.aspx	Obligations of relinquishing MCO: 1. Provide relevant information and submit the Enrollment Transition Information (ETI) for those members with special circumstances. 2. Cover the member's care for up to 30 days in the case of failure to provide relevant	**High-risk pregnancy:** Receiving MCO must allow beneficiary to stay with PCP.	1. **Transplantation services in process:** Relinquishing MCO will be responsible for the cost of all ongoing care at the time of transition. 2. **Chronic illness:** Receiving and	Relinquishing contractor will be financially responsible for all hospital services demanded during a transition to the receiving contractor.

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http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx	information to the receiving MCO. 3. Transfer medical records to receiving MCO. 4. Identify a transition coordinator to coordinate the transition of beneficiaries.		relinquishing MCOs must coordinate care. 3. **Medical conditions that require ongoing care from a specialist:** Receiving and relinquishing MCOs must coordinate care for patients with diabetes, hypertension, pain control, and orthopedic conditions. 4. **Those being treated with chemotherapy/radiation therapy and/or dialysis:** Receiving and relinquishing MCOs must coordinate care. 5. **Those with ongoing needs** such as DME (relinquishing MCO provides up to 15 days after switch), home health (relinquishing MCO must have procedure in place), medically necessary transport (relinquishing MCO must have procedure in place), prescription meds (relinquishing MCO provides up to 15 days after switch), and EPSDT benefits for qualified members (relinquishing MCO must have procedure in place). 6. **Those who have received prior authorization for:** procedures/therapies to be provided after the date of transition; sterilization for which consent form has been signed; specialist appointments outside the contractor service area; or nursing facility admission: authorized treatments must be honored by the receiving MCO.	

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Indiana http://www.docstoc.com/docs/25848527/RFS-7-62-ATTACHMENT-B-SAMPLE-CONTRACT	**Hoosier Healthwise requirements:** Relinquishing MCO agrees to: 1. Provide phase-in/phase-out training. 2. Coordinate an orderly transition for beneficiary to coverage through the receiving MCO. **Care Select requirements:** Upon notice from the state, the relinquishing MCO will: 1. Provide phase-in and phase-out services for up to 120 days. 2. Negotiate a plan with a successor to determine the type of phase-in and phase-out services required. Plan will outline a training program and provide experienced personnel to assist with phase-in/phase-out process. Personnel are allowed to leave the relinquishing MCO to work with the receiving MCO if mutually agreeable. The relinquishing MCO will transfer all of an employee's fringe benefits to the receiving MCO. Relinquishing MCOs will be reimbursed for all phase-in/ phase-out costs.	**Hoosier Healthwise requirement:** A receiving contractor must reimburse for and honor request of a pregnant woman in her third trimester to continue to receive care from current physician.	**Hoosier Healthwise requirement:** Receiving MCOs must honor previous care authorizations for a minimum of 30 calendar days.	**Hoosier Healthwise requirements:** Relinquishing MCO responsible for care coordination after the member has disenrolled if disenrollment occurs during an inpatient stay. 1. Relinquishing MCO financially responsible for the hospital DRG payment and outlier payments. 2. Relinquishing MCO must coordinate discharge plans with the receiving MCO.
Massachusetts	**MCO transition and contract readiness**: Review conducted of the following elements: 1. Network provider composition and access; 2. Staffing; 3. Marketing materials; 4. Capabilities of material subcontractors; 5. Care management capabilities; 6. Content of provider contracts; 7. Enrollee services capabilities;	**Pregnant women:** 1. If a pregnant enrollee enrolls with the contractor during the transition period, she may choose to remain with her current provider of obstetrical and	**Behavioral health provider network:** If there are significant changes, the contractor will determine the number of affected enrollees and the specific steps taken to assure that enrollees continue to have access to medically necessary services. **Special health care needs enrollees:**	

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	8. Comprehensiveness of quality management/ quality improvement and utilization management strategies; 9. Internal grievance and appeal policies and procedures; 10. Fraud and abuse and program integrity; 11. Financial solvency; and 12. Information systems. The contractor will implement policies and procedures to ensure continuity of care for new enrollees: 1. For the purpose of minimizing the disruption of care and ensuring uninterrupted access to Medically Necessary Services. 2. At a minimum, will address the following: a) Pregnant women; b) Those with significant health care needs or complex medical conditions; c) Those receiving ongoing services such as dialysis, home health, or chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition; and d) Those who received prior authorization for services such as scheduled surgeries, out-of-area specialty services, or nursing home admission from the relinquishing contractor.	gynecological services, even if that provider is not in-network. 2. Contractor is required to cover all medically necessary obstetrical and gynecological services through delivery of the child, post-partum care, and follow-up appointments within the first six weeks of delivery. If the enrollee would like to select a new provider within the network, she may do so.	Transition plan must be completed no later than 10 business days from when contractor becomes aware of enrollee's health status but no later than 45 days after enrollment. Transition plan should be specific to health needs and at a minimum should include: 1. Medical record documentation; 2. HRA completion; 3. Evaluation for care management; 4. Coordination and consultation with existing providers; 5. Review of existing prior authorizations and prescriptions; and 6. Coordination and consultation with other state agencies, if needed. **Transition from another MassHealth-contracted MCO:** The contractor will honor all prior authorizations and prior approvals. If the contractor chooses to modify or terminate a prior authorization, they must treat as an Adverse Action.	
Minnesota	Receiving MCO must cover previously authorized services, but it can require that the beneficiary see an in-network provider, if this stipulation does not create undue burden.	**Pregnancy:** Cases in which pregnancy services are covered by receiving MCO: At-risk pregnancy:	**Chemical dependency and mental health:** Both treatment and treatment-related room and board must be covered by the relinquishing MCO. The relinquishing MCO must develop a	

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		1. If in third trimester; and 2. If PC reports the pregnancy is high-risk. May continue to see an out-of-network provider. The receiving MCO is not responsible for out-of-network care after the hospital discharge of the mother and child.	transition plan for the beneficiary receiving mental health services. **Orthodontia:** Cases in which orthodontia is covered by the receiving MCO: 1. If authorized; 2. Necessary under an established plan of care; and 3. Care plan has a definitive end date. MCO must pay the orthodontia provider at minimum the state Medical Assistance fee-for-service rate. **Pharmaceuticals:** The receiving MCO must pay for all drugs currently taken by the beneficiary, except for those covered by Medicare Part D.	
New Mexico	1. Relinquishing MCO expected to develop a detailed plan addressing clinical transition issues and transfer of potentially large numbers of members. 2. Relinquishing MCO will develop a detailed plan for transitions of individual members. The relinquishing MCO must also be able to provide data and clinical information to receiving MCO. Extends to transitions between Salud!, State Coverage Insurance (SCI), Coordination of Long Term Services (CoLTS), and Fee-for-Service (FFS) programs including Premium Assistance programs.	**Pregnant women:** In the third trimester, women enrolled in a new MCO may stay with the same obstetrical provider, whether contracted or out-of-network.	**Salud! member requirements:** Prior authorization and provider payment requirements: 1. Receiving MCO must honor prior authorizations for 30 days or until it arranges for a transition of services. 2. Receiving MCO must pay for prescription drugs for the first 30 days or until it has made other arrangements. **CoLTS requirements:** The relinquishing MCO must: 1. Honor all prior authorizations for	**Hospital stays:** **<u>Salud! members</u>** Relinquishing MCO must cover all hospital expenses provided by a general acute-care or rehabilitation hospital until discharge from the hospital if the member is hospitalized at the time the member becomes exempt. If member disenrolled from Salud! because they have become eligible for and enrolled in the CoLTS program, the relinquishing contractor will be responsible for the payment for the initial

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States/ Agencies	**General**	**Special Populations: Maternity Care**	**Special Populations: Chronic or Acute Medical Conditions**	**Hospital Stays**
			the first 60 calendar days of enrollment or until other arrangements for transition of services are made. 2. Pay for prescription drugs for the first 90 days or until it has made other arrangements. 3. Accept prior authorization for long-term nursing facility placement and DME, personal care services. 4. Reimburse non-network providers at Medicaid FFS rate. **Salud! and CoLTS requirement:** Receiving MCO must pay for up to $2,000 of DME for equipment approved but not received by member until after disenrollment from the relinquishing MCO.	hospital stay, including professional services through the last day of the month of the last capitation payment. **SCI member requirements:** The contractor will track members who are nearing the annual claims benefit maximum or annual bed-day maximum by: 1. Tracking dollars paid for claims and hospital inpatient days and identifying those who have utilized a large portion of their inpatient resources. 2. Providing care coordination to high utilizers to prevent members from reaching benefit claims and/or hospital day maximums.
New York		Transitional period will continue for remainder of pregnancy up to 60 days after delivery if the enrollee is in second trimester at time of enrollment.	If enrollee has a life-threatening disease or condition, the receiving MCO will permit the enrollee to continue treatment with a non-participating provider during a 60-day period from enrollment. 1. Care with non-participating provider will be authorized by receiving MCO for transitional period if non-participating provider adheres to contractor's policies, procedures, and quality assurance requirements, and accepts contractor-defined reimbursement rates. For enrollees whose provider has left	**Hospital Stays:** Relinquishing MCO must pay for a beneficiary's hospital stay if she is hospitalized on the day of disenrollment, UNLESS she is transferred to a different hospital OR is transferred to a different unit in the same hospital and method of payment changes from DRG-based to per diem OR per diem to DRG-based.

Managing Coverage Transitions: State and National Models (effective April 2012)				
States/ Agencies	**General**	**Special Populations: Maternity Care**	**Special Populations: Chronic or Acute Medical Conditions**	**Hospital Stays**
			the network, the receiving MCO should allow member to continue course of treatment with current provider for up to 90 days.	
Pennsylvania http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s_002381.pdf	1. Daily and Monthly Membership Files with changes to membership are provided to each physical health (PH) MCO. PH-MCO must provide the same level of coverage for each member in the file, from the first day of the month or the PH-MCO coverage start date (whichever is later) through the last day of the month or the PH-MCO end-date. 2. Those who move out of the PH-MCO's service area may still be covered by their PH-MCO, pursuant to review by County Assistance Office (CAO). 3. Members who become ineligible for Medicaid retain coverage with their PH-MCO for six months. If they requalify for Medicaid within those six months, they again become the responsibility of the PH-MCO. **Dual Eligibles:** Dual eligibles enrolled in Medicare Part D who turn 21 will be identified on the first Friday of every month and disenrolled from their PH-MCO. Newly identified dual eligibles will be disenrolled from their PH-MCO at the end of the month in which Medicare Part D is posted to their eligibility record.	**Newborns:** Should be covered by PH-MCO covering mother, unless Children and Youth assumes custody of the newborn.	**Medical Necessity:** State may require continuation of care by relinquishing PH-MCO for cases in which there is medical necessity.	**Change in coverage while in hospital:** 1. ***FFS to PH-MCO:*** PH-MCO becomes responsible for expenses at the begin date of PH-MCO coverage. 2. ***PH-MCO:*** PH-MCO is responsible for coverage unless the recipient is still in the hospital during the FFS begin date, in which case FFS begins to pay. 3. ***Transfer between PH-MCOs:*** The relinquishing PH-MCO is responsible for coverage up until the receiving PH-MCO's begin date, unless the begin date is not the first of the month. 4. ***Recipient loses and regains Medicaid eligibility while in hospital:*** PH-MCO coverage will extend retroactively to cover the lapse in coverage due to ineligibility. 5. ***Recipient loses and regains Medicaid eligibility once discharged from the hospital:*** PH-MCO covers through the end of the month and FFS kicks in until the date of discharge. 6. ***Recipient never regains Medicaid eligibility:*** PH-MCO only responsible for coverage until the end of the month.