STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

TENNCARE LONG TERM SERVICES & SUPPORTS

OPERATIONAL PROTOCOL

Protocol Title	Transition of a CHOICES Member between Managed Care Organizations
Effective Date	July 1, 2012

Background:

One of the unique aspects of Tennessee's CHOICES program is that all Medicaid populations in Tennessee have been enrolled into managed care for physical and behavioral health care since 1994. Rather than contracting with new managed care entities to deliver long-term care services, long-term care services are being integrated within the existing managed care delivery system, so members are not required to change MCOs in order to access long-term care services and supports. This will help facilitate a more seamless transition and continuity of care for CHOICES participants.

While implementation of the CHOICES program will not result in assignment of members receiving long-term care to new health plans, TennCare members do have the option to change MCOs once a year and based on hardship reasons as set forth under TennCare Rules.

When a member transitions from one MCO to another MCO (even voluntarily), in many cases, services and/or relationships with providers may be disrupted. Further, medical information compiled over a period of months or even years may not be forwarded to or gathered by new care providers and care managers. The member's new plan of care may change, resulting in adjustments to the type and/or level of services authorized. Key to minimizing the potential negative consequences of a CHOICES member's transition between MCOs is communication and collaboration between the sending and receiving MCO—in particular, the care coordinator and care coordination team of both the sending and receiving MCO who provide day-to-day monitoring and oversight of a member's physical and behavioral health, and long-term care service needs.

Requirements:

Applicable CRA references include:

The MCO Contractor Risk Agreement sets forth requirements regarding transition of CHOICES members between MCOs in Section 2.9.6.2.1.4.

For covered long-term care services for CHOICES members who are transferring from another MCO, the CONTRACTOR shall be responsible for continuing to provide covered long-term care services and supports, including both HCBS authorized by the transferring MCO and nursing facility services, without regard to whether such services are being provided by contract or non-contract providers.

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The section prescribes continuity of care provisions for each CHOICES group, as well as the timelines for conducting an initial face-to-face visit, completing a comprehensive needs assessment, developing a plan of care, as applicable, and authorizing and initiating long-term care services.

The following section requires the transfer of information between the sending and receiving MCO that is critical to ensuring continuity of care for the transitioning member.

If a member enrolls in the CONTRACTOR's MCO from another MCO, the CONTRACTOR shall immediately contact the member's previous MCO and request the transfer of "transition of care data" as specified by TENNCARE. If the CONTRACTOR is contacted by another MCO requesting "transition of care data" for a member who has transferred from the CONTRACTOR to the requesting MCO (as verified by the CONTRACTOR), the CONTRACTOR shall provide such data in the timeframe and format specified by TENNCARE.

Protocol:

This protocol sets forth the responsibilities of the sending and receiving MCO in facilitating the transition of CHOICES members between MCOs, and the form, format, and timeframe for exchange of "transition of care data" between the sending and receiving MCO.

Objectives

The objectives of this MCO transition protocol are to:

- Whenever possible, plan for transitions between MCOs.
- Support high level communication between MCOs.
- Consistently provide for the transfer of all needed medical information on behalf of the transitioning member.
- Facilitate as seamless a transition as possible between MCOs.

Responsibilities of the Sending MCO

When an MCO is aware that a CHOICES member will be transitioning to another MCO, the care coordinator and care coordination team shall assist the member in transitioning from the current MCO to another MCO. The care coordinator and/or care coordination team's responsibilities include:

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- Upon learning that a member will be transitioning to a new MCO, initiating contact with the receiving MCO to help plan for the transition.
- Identifying potential barriers and risks that may occur in transition, and working with the receiving MCO to develop and implement strategies to eliminate barriers and minimize risks.
- Ensuring that the member's demographic information, needs assessment, plan of care, risk assessment, risk agreement, and other transition of care data are up-to-date.
- Forwarding all appropriate member documents and information, as reflected below in ***Transition of Care Data,*** to the member's new MCO.
- Contacting the new MCO to ensure that all relevant member documents and information were received and to determine if any additional information is needed.
- Verifying that the member has the new MCO contact information, or provide to the member if necessary.
- Answering the member's questions about the transition process.
- Notifying the member regarding applicable continuity of care provisions, (i.e., for CHOICES Group 2 and 3 members, that s/he will continue to receive services based on the current plan of care for at least 30 days after transition, and until the new MCO has completed a comprehensive needs assessment and developed and implemented a new plan of care).
- Being sure the member is aware that some service providers (physical, behavioral, and/or long-term care) may not contract with the new MCO, requiring the member to change providers upon expiration of the continuity of care period.
- Contacting providers and the FEA/Supports Broker (as applicable) to ensure they are aware of the member's transition, continuity of care provisions, and to help ensure that services continue without interruption at transition.

The care coordinator from the sending MCO shall respect the member's decision to change MCOs, focus on the member's needs, and make all necessary efforts to transition the member without any additional risk to the member's health and safety. The care coordinator shall not attempt to convince a member to make a decision to transition or not transition to a new MCO. The care coordinator's role in a transition is to answer the member's questions, and to help facilitate as seamless a transition as possible.

Responsibilities of the Receiving MCO

The receiving MCO shall ensure compliance with all contract requirements including applicable continuity of care provisions for each CHOICES group, as well as the timelines for conducting an initial face-to-face visit, completing a comprehensive needs assessment and developing a plan of care, as

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applicable, and authorizing and initiating long-term care services and supports. Additional responsibilities of the member's receiving MCO's care coordinator and/or care coordination team include:

- Contacting the sending MCO to obtain transition of care data, if such has not been received.
- Reviewing all transition of care data forwarded by the previous MCO.
- Requesting any relevant documents and information not received.
- Immediately identifying potential barriers and risks that may occur in transition, and work with the sending MCO to develop and implement strategies to eliminate barriers and minimize risks.
- Answering the member's questions about the transition process.
- Providing the member with contact information for his/her new care coordinator/ care coordination team.
- Notifying the member specifically which, if any, current service providers must change due to their status as a non-contract provider, the process for transition, and facilitating the member's selection of contract providers.
- Reinforcing the member's understanding regarding applicable continuity of care provisions, (i.e., for CHOICES Group 2 and 3 members, that s/he will continue to receive services based on the current plan of care for at least 30 days after transition, and until the new MCO has completed a comprehensive needs assessment and developed and implemented a new plan of care).
- Contacting providers and the FEA/Supports Broker (as applicable) to ensure they are aware of the member's transition, continuity of care provisions, and to help ensure that services continue without interruption at transition.
- Monitoring services via the electronic visit verification system and contact with the member and/or service providers, as necessary, to ensure that services continue without interruption during the transition period.

Transition of Care Data

The following information shall be provided by the care coordinator or care coordination team of the sending MCO to the care coordinator or care coordination team of the receiving MCO via secure fax or secure email.

- Current member demographics including member address and phone number(s)
- Member's authorized representative or family member and phone number(s)
- Member's most recent comprehensive needs assessment (including assessment of the member's natural support system)
- Member's most recent level of care assessment (PAE)
- Member's most recent transition assessment and transition plan

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- Member's current plan of care with signature page, including detailed back-up plan, or for Group 1 members, supplements to the NF plan of care
- Member's most recent risk assessment and signed risk agreement
- Member's signed Freedom of Choice form
- All open service authorizations (physical and behavioral health, and long-term care), and the authorized provider(s) of each service
- Consumer directed services including service schedules, self-assessment, current representative agreement, service agreement(s), and the name and contact number of the member's Supports Broker
- Documentation regarding self-direction of health care tasks
- Disease Management programs, including DM activities conducted with the member
- Member's cost neutrality determination
- Member's year-to-date cost neutrality cap expenditures (i.e., HCBS and HH/PDN)
- Member's service utilization history, including at a minimum, NF/SNF, HCBS, HH/PDN
- Member's year-to-date and lifetime (as applicable) benefit limit expenditures