

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral and Physical Health & Aging Services Administration

TRANSITION OF CARE TECHNICAL REQUIREMENT

SUMMARY

The Centers for Medicare and Medicaid Services (CMS) defines transition of care as the movement of an enrollee from one setting of care to another.¹ This movement can pose challenges to effective coordination between responsible entities when an enrollee transitions from one setting of care to another. As enrollees move between service delivery providers, it is important to maintain continuity of care for each enrollee while minimizing burden on service providers during the enrollee's transition.

DEFINITIONS

Continuity of Care: The quality of care over time, including both the enrollee's experience of a "continuous caring relationship" with an identified health care professional and the delivery of a "seamless service" through integration, coordination, and the sharing of information across different providers/care settings.

Care Coordination/Coordination of Care: The organization of an enrollee's care across multiple health care providers.

Enrollee: A Medicaid beneficiary with substance use disorder (SUD), mental illness, serious emotional disturbance or developmental disability who is eligible for specialty mental health services and supports.

Managed Care Entity: 42 CFR 438 recognizes a Prepaid Inpatient Health Plan (PIHP) as a managed care entity. A PIHP is responsible for management of specialty services related to mental health, developmental disability services, and certain SUD services to Michigan residents enrolled in Medicaid.

Receiving Entity: The PIHP that is opening for services the transitioning enrollee and receiving the enrollee's information.

Setting of Care: Generally, a place where an enrollee is provided mental health and/or SUD services, including the diagnosis, treatment, and assessment of emotional and mental health disorders and issues. This can include inpatient and outpatient facilities, in-home care, adult care homes, and more.

Transition of Care: The movement of an enrollee from one setting of care to another.

Transferring Entity: The PIHP that is closing for services the transitioning enrollee and transferring the enrollee's information.

Warm Handoff: Time-sensitive, enrollee-specific planning identified by either the Transferring Entity or the Receiving Entity to ensure continuity of care during transition from one setting of care to another. Warm handoffs require collaborative planning between both entities and when at all possible, collaborative planning should occur prior to the transition.²

POLICY REQUIREMENTS

Medicaid services must be provided without delay to any Medicaid enrollee of a PIHP for any and all reasons other than ineligibility for Medicaid (42 CFR 438.62(a)).

1. The PIHP must develop and implement a transition of care policy consistent with 42 CFR 438.62 to ensure continuity of care for its enrollees. The PIHP should take into consideration the impact on an enrollee's health if losing access to the enrollee's established providers.
 - a. The PIHP transition of care policy must ensure continued access to services during a transition from fee-for-service (FFS) to a Managed Care Organization (MCO), PIHP, Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), or PCCM entity or transition from one MCO, PIHP, PAHP, PCCM, or PCCM entity to another when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. (42 CFR 438.62(a)).
 - b. The PIHP must make its transition of care policy publicly available and must provide instructions to enrollees and potential enrollees on how to access continued services upon transition.
 - c. The PIHPs transition of care policy must be explained to individuals in materials to enrollees and potential enrollees in accordance with 42 CFR 438.10.
 - d. The transition of care policy must include, at a minimum:
 - i. Assurance that enrollees who are transitioning have access to services consistent with the access the enrollee previously had.
 - ii. Assurance that the enrollee has access to services consistent with the access the enrollee previously had and is permitted to retain the enrollee's current provider for a minimum of 90 days if the enrollee's current provider is not in the Receiving Entities network. The Receiving Entity must assist the enrollee in selecting an in-network provider. Ninety (90) days is the minimum timeframe required, and the PIHP has the option to extend the time period at its discretion (42 CFR 438.62(b)(1)(i)(ii)).
 - iii. The requirement that transitioning enrollees are referred to appropriate providers within the Receiving Entities provider network.

- iv. Any other necessary procedures are in place to ensure continued access to services for enrollees who have an ongoing special condition and/or to prevent serious detriment to the enrollee's health or reduce the risk of hospitalization or institutionalization.
- v. The Transferring Entity previously serving an enrollee must, within 14 calendar days, fully comply with requests for historical utilization, providing data, medical records, and other documentation as appropriate to the enrollee's newly Receiving Entity, or requests from MDHHS.
- vi. A process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR 170.213. Information received by the Receiving Entity must be incorporated into the records of the enrollee. With the approval and/or at the direction of a current or former enrollee or an enrollee's personal representative, the PIHP must:
 - 1. Receive all such data for a current enrollee from any other payer that has provided coverage to the enrollee within the preceding five (5) years.
 - 2. At any time, while the enrollee is open for services with the PIHP and up to five (5) years after closure of services, send all such data to any other payer that covers the enrollee or a payer that the enrollee or the enrollee's personal representative specifically requests receive the data; and
 - 3. Send data received from another payer in the electronic form and format it was received (42 CFR 438.62(b)(1)(vi)).
 - 4. With respect to any data protected by 42 CFR Part 2, attempts must be made in good faith and with due diligence to obtain appropriate consent from the enrollee (or other individual legally authorized to consent under 42 CFR Part 2) to release the enrollee's information for the purposes generally required within this technical requirement. If such consent is not obtained, data protected by 42 CFR Part 2 is not required to be shared when there is not another legally permissible basis for disclosure.
- vii. Applicability – The PIHP must comply with the requirements of this section, regarding:
 - 1. Data with a date of service on or after January 1, 2016; and
 - 2. Data that is maintained by the PIHP.³⁴
- viii. Staff training on transition of care standards.⁴

STANDARDS

Transition of Care processes aim to improve the quality of care, enhance outcomes, and control costs with entities working together to develop plans for enrollees that eliminate service barriers. A solid foundation for an effective transition of care plan includes open and timely communication of information between the Transferring Entity and the Receiving Entity.

1. The PIHPs transition of care shall integrate processes and procedures for managing and coordinating the transition of a managed care enrollee. These include, but are not limited to:
 - a. Every good faith effort must be made to ensure that a Transition of Care Plan is developed and put into place or that accurate information is available to support medical decisions by patients and providers, thoroughly documenting any denial of participation and the reasoning.
 - b. Ensuring a transition of care plan is developed between providers when an enrollee is transitioning from one care setting to another. The plan must be created with the enrollee, family members and/or guardians, and other appropriate providers, with follow up to communicate the transition of care plan to all involved.
 - c. The coordination of a timely “warm handoff” for effective knowledge transfer and to ensure enrollee continuity of care. The “warm handoff” also applies to minors, with clear coordination and explanations of changes that occur when a youth turns 18 and transitions to the adult mental health care system.
 - d. The promotion of proactive communication by the Transferring Entity with the Receiving Entity prior to transition to coordinate the transfer of care.
 - e. Establishing a protocol to follow-up by communicating with the Receiving Entity within 14 calendar days after the enrollee’s transition to confirm receipt of transferred information and to talk through any challenges that may have occurred during the transition.
 - f. Adherence to population-specific care management protocols to ensure continuity of care during the disenrollment and enrollment processes. This can include, but is not limited to, care management protocols surrounding movement of enrollees into and out of waiver services, of youth to adult services from children’s services, transitions of children to and from Child Caring Institutions, transitions of children and/or adults to and from Foster Care, transitions of enrollees involved with the court system, transitions of enrollees from inpatient care to outpatient care, and transitions from incarceration to community. Special attention must be paid to medication continuity during movement and transitions of enrollees from one setting of care to another to reduce the frequency of medication disruption in all enrollees, but especially in youth and children. This is not an exhaustive list and should not be interpreted as the only population-specific care management protocols needed to ensure continuity of care during the disenrollment and enrollment processes.

10. The PIHP must ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR part 160, subparts A and E and 45 CFR part 164, subparts A and E, to the extent that they are applicable.⁶
11. The PIHP must ensure that transition of care plans, processes, and procedures are in compliance with these requirements by performing regular (no less than annual) oversight and monitoring activities.

¹ [Transitions of Care | Agency for Healthcare Research and Quality \(ahrq.gov\)](https://www.aHRQ.gov)

² NCDHHS Transition of Care Policy 20230404v1.5

³ 42 CFR 438.62 – Continued Services to Enrollees

⁴ NCDHHS Transition of Care Policy 20230404v1.5

Last Revision Date: November 18, 2024

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⁵ MDHHS/CMHSP Contract – County of Financial Responsibility Technical Requirement C1.3.1.

⁶ 42 CFR 438.208 – Coordination and Continuity of Care