



520 MEMBER TRANSITIONS

REVISION DATES: 03/01/2011, 11/01/07, 04/01/05, 10/01/01, 02/01/01, 07/22/96

INITIAL

EFFECTIVE DATE: 10/01/94

Contractors must identify and facilitate coordination of care for all AHCCCS members during changes or transitions between Contractors, as well as changes in service areas, subcontractors, and/or health care providers. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols must be developed to address these situations. Special circumstances include members designated as having “special health care needs” under Policy 540 of this Chapter, as well as members who have:

1. Medical conditions or circumstances such as:
 - a. Pregnancy (especially women who are high risk and in third trimester, or are within 30 days of their anticipated delivery date)
 - b. Major organ or tissue transplantation services which are in process
 - c. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other facilities, and/or
 - d. Significant medical conditions (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing specialist care and appointments.
2. Members who are in treatment such as:
 - a. Chemotherapy and/or radiation therapy, or
 - b. Dialysis.
3. Members with ongoing needs such as:
 - a. Durable medical equipment including ventilators and other respiratory assistance equipment
 - b. Home health services
 - c. Medically necessary transportation on a scheduled basis
 - d. Prescription medications, and/or
 - e. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.
4. Members who at the time of their transition have received prior authorization or approval for:
 - a. Scheduled elective surgery(ies)
 - b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits
 - c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period



- d. Appointments with a specialist located out of the Contractor service area, and
- e. Nursing facility admission.

A. NOTIFICATIONS REQUIRED OF CONTRACTORS

1. Relinquishing Contractors must provide relevant information regarding members who transition to a receiving Contractor. The Enrollment Transition Information (ETI) form must be transmitted for at least those members with special circumstances, listed in this policy, who are transitioning enrollment to another Contractor. There are three specific ETI forms:
 - a. Exhibit 520-1 is used by the acute care Contractors.
 - b. Exhibit 520-2 is used by the Children's Rehabilitative Services (CRS) when transitioning a member who is turning 21 years of age.
 - c. Chapter 1600, Policy 1620, Exhibit 1620-9, is used by ALTCS Contractors.
2. Relinquishing Contractors who fail to notify the receiving Contractors of transitioning members with special circumstances, or fail to send the completed ETI form, will be responsible for covering the member's care resulting from the lack of notification, for up to 30 days.

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

3. Contractors must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, subcontractors or other providers, as appropriate during times of transition.
4. Receiving Contractors must provide new members with their handbook and emergency numbers as specified in Contract and ACOM Policy 404.
5. Receiving Contractors must follow up as appropriate for the needs identified on the ETI form.

B. AHCCCS TRANSITION POLICIES

AHCCCS has specific policies for member transition issues including, but not limited to:

1. Transition to an ALTCS Contractor from an acute care Contractor
2. Transition to an acute care Contractor from an ALTCS Contractor
3. County to county transitions



4. Transition to an acute care or ALTCS Contractor by a CRS member who is turning 21 years of age
5. Transition of members hospitalized during an enrollment change
6. Transition during major organ and tissue transplantation services
7. Enrollment changes for members receiving outpatient treatment for significant conditions
8. Transfer and interim coverage of prescription medications
9. Disposition of durable medical equipment, orthotics, prosthetics and other medical supplies, and
10. Transfer of medical records

C. TRANSITION TO ALTCS

If a member is referred to and approved for ALTCS enrollment, the acute care Contractor must coordinate the transition with the assigned ALTCS Contractor to assure that applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition.

Refer to Chapter 1600, Policy 1620 of this Manual for ALTCS Contractor responsibilities in the transition process.

D. TRANSITION TO ACUTE CARE CONTRACTOR FROM ALTCS CONTRACTOR

If a member is determined through Pre-Admission Screening (PAS) reassessment to no longer need long term care through ALTCS or the ALTCS-Transitional program, and the member is determined eligible for acute care enrollment, he/she will be transitioned to an acute care Contractor. The ALTCS Contractor will receive a prior plan list for members that are being disenrolled. The ALTCS Contractor uses this list to identify members needing an ETI form completed and forwards it and any other appropriate information to the acute care Contractor. The member's ALTCS case manager must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained.

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

1. Conduct a comprehensive evaluation to determine the treatment and service regimen. The member must continue receiving the ALTCS treatment and service



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

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

E. COUNTY TO COUNTY TRANSITIONS

1. Acute care Contractors are responsible for coverage of emergency services for members included on their member roster on the date the service was provided. This applies to members who have moved out of the acute care Contractor service area.
2. If an ALTCS member moves out of a service area, but not out of the state, the ALTCS Contractor(s) may remain responsible for all services, dependent upon whether the member is institutionalized or receiving home and community based services.
3. If a Contractor has service areas in multiple counties of the State and a member moves to a new service area that the Contractor serves, the member will remain enrolled with that Contractor. The Contractor is responsible for informing the members in writing that any change in address must be submitted to the member's eligibility determination agency, at which point eligibility will be reevaluated.

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

4. Contractors are responsible for the facilitation of enrollment transfers and ensuring that services for members are not interrupted.

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

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



1. Initiate a transition plan by the age of 20 years which is ongoing until the member leaves the CRS program. The transition plan must:
 - a. Establish a plan that is age appropriate and addresses the current transition needs of the member (i.e., health condition management, developmental and functional independence, education, social and emotional health, guardianship, transportation)
 - b. Ensure families, members, and their primary care providers are part of the development and implementation of the transition plan
 - c. Document the transition plan in the medical record
 - d. Provide family and member with a copy of the transition plan
 - e. Establish a timeline for completing all services the member should receive through CRS prior to his or her twenty-first birthday
 - f. Review and update the plan and timeline with member and family prior to official transition to adult provider
 - g. Advise the member's primary care provider of the discharge and ensure coordination of the services with the adult primary care provider.
2. Coordinate the transition plan with the appropriate entity:
 - a. AHCCCS acute care or ALTCS contractors or
 - b. IHS and Tribal entities upon discharge from a CRS clinic and/or discharge
 - i. FROM THE CRS PROGRAM.
3. Submit the CRS ETI form (Exhibit 520-2) to the receiving (acute care or ALTCS) Contractor transition coordinator 90 days prior to the member's 21st birthday
4. Include medical records as appropriate
5. Coordinate with the receiving AHCCCS Contractor utilization management staff, hospital staff and PCP when the member is in the hospital on his/her 21st birthday, and
6. Be accountable for all other timeframes and processes noted in this policy as applicable.

G. MEMBERS HOSPITALIZED DURING AN ENROLLMENT CHANGE

1. The Contractor will make provisions for the smooth transition of care for members who are hospitalized on the day of an enrollment change. The provisions must include protocols for the following:
 - a. Authorization of treatment by the receiving Contractor on an individualized basis. The receiving Contractor must address contracting for continued treatment with the institution on a negotiated fee basis, as appropriate.
 - b. Notification to the hospital and attending physician of the transition by the relinquishing Contractor. The relinquishing Contractor must notify the hospital and attending physician of the pending transition prior to the date of



the transition and instruct the providers to contact the receiving Contractor for authorization of continued services. If the relinquishing Contractor fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing Contractor will be responsible for coverage of services rendered to the hospitalized member for up to 30 days. This includes, but is not limited to, elective surgeries for which the relinquishing Contractor issued prior authorization.

- c. Coordination with providers regarding activities relevant to concurrent review and discharge planning must be addressed by the receiving Contractor, along with the mechanism for notification regarding pending discharge.
- d. Transfer of care to a physician and/or hospital affiliated with the receiving Contractor. Transfers from an out-of-network provider to one of the receiving Contractor providers cannot be made if harmful to the member's health and must be determined medically appropriate. The transfer may not be initiated without approval from the relinquishing Contractor primary care provider, or the receiving Contractor Medical Director.

Note: Members in Critical Care Units, Intensive Care Units and Neonatal Intensive Care Units require close consultation between the attending physician and the receiving Contractor physician. If a member is admitted to an inpatient facility while still assigned to the relinquishing Contractor, and discharged after transition to the receiving Contractor, both must work together to coordinate discharge activities.

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

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

H. TRANSITION DURING MAJOR ORGAN AND TISSUE TRANSPLANTATION SERVICES

1. If there is a change in Contractor enrollment, both the relinquishing and receiving Contractors will be responsible for coordination of care and coverage for members awaiting major organ or tissue transplantation from the time of transplantation evaluation and determination through follow-up care after the transplantation surgery. If a member changes Contractor enrollment while undergoing transplantation at an AHCCCS-contracted transplant center, the relinquishing Contractor is responsible for contracted components or modules of



the service up to and including completion of the service modules that the member is receiving at the time of the change. The receiving Contractor is responsible for the remainder of the module components of the transplantation service.

2. If a member changes to a different Contractor while undergoing transplantation at a transplant center that is not an AHCCCS-contracted provider, each Contractor is responsible for its respective dates of service. If the relinquishing Contractor has negotiated a special rate, it is the responsibility of the receiving Contractor to coordinate the continuation of the special rate with the respective transplant center.

I. ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT FOR SIGNIFICANT MEDICAL CONDITIONS

1. Contractors must have protocols for ongoing care of active and/or chronic "high risk" (e.g., outpatient chemotherapy, home dialysis, etc.) members and pregnant members during the transition period. The receiving Contractor must have protocols to address the timely transition of the member from the relinquishing Primary Care Provider (PCP) to the receiving PCP, in order to maintain continuity of care.
2. The receiving Contractor must address methods to continue the member's care, such as contracting on a negotiated rate basis with the member's current provider(s) and/or assisting members and providing instructions regarding their transfer to providers affiliated with the receiving Contractor.
3. Receiving Contractors are also responsible for coordinating the transition of pregnant women to maintain continuity of care. Pregnant women who transition to a new Contractor within the last trimester of their expected date of delivery must be allowed the option of continuing to receive services from their established physician and anticipated delivery site.

J. TRANSITION OF MEDICALLY NECESSARY TRANSPORTATION

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

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

Refer to Chapter 300 for complete information regarding transportation service coverage.



Refer to Chapter 800 for complete information regarding FFS transportation coverage.

K. TRANSITION OF PRESCRIPTION MEDICATION SERVICES

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

1. Relinquishing Contractors must cover the dispensation of the total prescription amount of either continuing or time-limited medications, if filled before midnight on the last day of enrollment. The relinquishing Contractor must also provide sufficient continuing medications for up to 15 days after the transition date.
2. Receiving Contractors must address prior authorization of prescription medication and refills of maintenance medication within 14 days of the member's transition.
3. The relinquishing Contractor must provide notice to the receiving Contractor primary care provider of transitioning members who are currently taking prescription medications for medical conditions requiring ongoing use of medication, such as, but not limited to, immunosuppressant, psychotropic and cardiovascular medications, or unusually high cost medications.

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

Refer to Chapter 300 for complete information regarding prescription medication coverage.

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

Contractors must address the disposition of Durable Medical Equipment (DME) and other medical equipment during a member's transition period and develop protocols that include the following:

1. Non-customized DME
 - a. The relinquishing Contractor must provide transitioning members with DME for up to 15 days after the transition date or until the receiving Contractor supplies the service. The receiving Contractor must supply necessary DME within 14 days following the transition date.
 - b. To facilitate continuity of services, the receiving Contractor is encouraged to:



- i. Negotiate and/or contract for continued services with the member's current provider, and/or
- ii. Provide instructions and assistance to new members on how to transfer to a DME provider who belongs to the new Contractor network.

- c. The receiving Contractor must assess medical necessity of DME if equipment was rented by the relinquishing Contractor.

2. Customized DME:

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

- a. Customized DME purchased for members by the relinquishing Contractor will remain with the member after the transition. The cost of the equipment is the responsibility of the relinquishing Contractor.
- b. Customized DME ordered by the relinquishing Contractor but delivered after the transition to the receiving Contractor will be the financial responsibility of the relinquishing Contractor.
- c. Maintenance contracts for customized DME purchased for members by a relinquishing Contractor will transfer with the member to the new Contractor. Contract payments due after the transition will be the responsibility of the receiving Contractor, if they elect to continue the maintenance contract.

3. Augmentative Communication Devices (ACDs)

A 90 day trial period is generally necessary to determine if the ACD will be effective for the member, or if it should be replaced with another device.

If a member transitions from one Contractor to another during the 90 day trial period, one of the following will occur:

- a. If the ACD is proven to be effective, the device remains with the member. Payment for the device is the responsibility of the relinquishing Contractor. The cost of any maintenance contract necessary for the ACD becomes the responsibility of the receiving Contractor, if they elect to continue the maintenance contract, or
- b. If the ACD is proven to be ineffective, it is returned to the relinquishing Contractor. The receiving Contractor must reassess the member's medical condition and purchase a new device if it is determined to be potentially effective in meeting the member's needs.

Note: If the member has had the ACD for more than a 90 day trial period, the customized DME process in section 2 applies.



Refer to Chapter 300 for additional information regarding DME.

M. MEDICAL RECORDS TRANSFER DURING TRANSITION

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

To ensure continuity of member care during the time of enrollment change, Contractors must have the following procedures in place to ensure timely medical records transfer:

1. Procedure to be used by the relinquishing Contractor PCP to transfer member records to the receiving Contractor PCP.
2. Procedure regarding:
 - a. The portions of a medical record to copy and forward to the receiving Contractor PCP. The relinquishing PCP must transmit at least those records related to diagnostic tests and determinations, current treatment services, immunizations, hospitalizations with concurrent review data and discharge summaries, medications, current specialist services, behavioral health quarterly summaries and emergency care.
 - b. A defined timeframe for the receipt of medical records by the receiving PCP (i.e., on the date of transfer, after hospital discharge, prior to transfer).
3. Maintaining confidentiality of each member's medical records. In accordance with Federal or State laws and Court orders, Contractors must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 C.F.R. 431.300 *et seq.*
4. Transfer of other requested medical records, exceeding the requirements of this policy, including resolution of payment for copying and transmitting medical record data.

Refer to Policy 550 of this Chapter, Chapter 600 and Chapter 900 for additional AHCCCS requirements related to medical records and confidentiality.