Upper Peninsula Health Plan
Policy & Procedure

Index #:	300-035	**Effective:**	02/01/2021
Subject:	Transition of Care	**Revised:**	

Authorized By: _____ **Date:** _____ **Title: Medical Director**

Authorized By: _____ **Date:** _____ **Title: CEO**

Product Type(s): ☐ **All Products** ☒ Medicaid ☒ Healthy Michigan Plan
☐ Medicare ☒ MIChild ☐ MI Health Link

Purpose

Describe Upper Peninsula Health Plan (UPHP) measures to assure members newly enrolled in UPHP, whose health would be jeopardized if health care services ceased or were disrupted during their transition from Fee for Service (FFS) to UPHP or from a different Medicaid Health Plan (MHP) to UPHP, receive no disruption in current services, which also includes prescription drugs and providers which are not part of the UPHP network, in accordance with the state Medicaid contract.

Definitions

Maintenance drug: a drug where the member has received a 30-day supply of the drug in the previous 90 days.

Medical Necessity: For transition of care purposes, medical necessity is met if the service:

- Meets generally accepted standards of medical practice
- Is clinically appropriate in its type, frequency, extent, duration, and delivery setting
- Is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome
- Provides unique, essential, and appropriate information if it is used for diagnostic purposes, and
- It is not provided primarily for the economic benefit or conveniences of anyone other than the member.
- The enrolling health plan must honor the disenrolling health plan's prior authorization if any, for a period of 90 days from enrollment into the new health plan and the prior authorization document should be submitted by the member or provider. The health plan may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service.

Out-of-Network Providers: Providers include primary care providers (PCP), specialists, clinics, and dentists.

Policy

This policy applies to UPHP members, enrolled within the first 90 days, if during a transition, in the absence of continued access to necessary services, the member would suffer serious detriment to their health or be at risk of hospitalization or institutionalized when transitioning. UPHP shall address transition of care for all such members to ensure uninterrupted services which disrupt medically necessary services including but not limited to members who, at the time of their enrollment:

- Have significant health care needs or complex medical conditions
- Are receiving ongoing services such as dialysis, home health, chemotherapy, and/or radiation therapy.

The transitioned member is eligible for continued, clinically equivalent services by an equivalent provider, if, during the previous 6 months, the transitioned member was treated by that provider for a condition that requires follow-up care or additional treatment, or the services have been prior authorized by the previous health plan.

If Children Special Health Care Services (CSHCS) member transition requirements conflict with this transition of care policy requirements, CSHCS transition requirements shall supersede.

UPHP Interdisciplinary Transition of Care Team:

UPHP has an Interdisciplinary Transition of Care (ITC) team to implement this policy and provider oversight and manage all transition processes. This team includes at minimum, the UPHP Clinical Coordinator-Utilization Management (UM), who is a Registered Nurse, and UPHP Pharmacist. Other UPHP staff may include but not limited to the UPHP Clinical Coordinator- Children's Special Health Care Services (CSHCS) and Community Health Worker (CHW).

Prior Relationship with a Provider:

The UPHP member must have a relationship with a provider to establish continuity of care. UPHP will allow member access to any provider (even if the provider is not in the UPHP network) if they have seen the provider at least *once* within the six months prior to enrollment into UPHP for a nonemergency visit as indicated in CareConnect360 or other data available to UPHP. UPHP will review, assess and coordinate those services. If UPHP cannot determine if a relationship exists, UPHP will ask the provider and/or the member to provide documentation of the visit from the medical record or proof of payment to establish the relationship.

Requesting Continuity of Care Coverage:

To initiate continuity of care coverage, the member, his or her appointed representative, or the member's provider may request continuity of care on behalf of the member. Requests for

continuity of care can be made by contacting UPHP Customer Service, Utilization Management department or the member's UPHP Care Coordinator if applicable. Requests can be made verbally or in writing.

Coverage periods:

Primary Care Providers, Specialists, and other covered providers

- UPHP must maintain current providers and level of services at the time of enrollment for at least 90 days.
- For member's who meet transition of care criteria, UPHP must honor existing prior authorizations for at least 90 days:
    - Scheduled surgeries, dialysis, chemotherapy and radiation, organ, bone marrow, and hematopoietic stem cell transplants
- For services such as custom-fabricated and non-custom fabricated medical equipment and transportation and CSHCS population services, the coverage will be based on provisions outlined in the Medicaid contract and Medicaid Provider Manual.
- For member's providers that are no longer available to the member through the UPHP network, UPHP must allow the member to continue receiving services from the out-of-network provider for at least 90 days.
- UPHP will honor previous FFS/MHP prior authorizations for a period for at least 90 days from enrollment into UPHP.

Prescriptions

UPHP must provide a transition supply without prior authorization if:

- The member is taking a drug that is not covered by UPHP, or
- UPHP rules do not cover the amount ordered by the prescriber, or
- The drug requires prior authorization by UPHP, or
- The member is taking a drug that is part of a step therapy restriction.

For prescribed drugs, UPHP will not be more restrictive than requirements for Medicare Part D transition fills.

Member and Provider Education:

UPHP will make this policy publically available on the UPHP website. UPHP will also provide instructions to members and providers on how to access continued services, upon transition, in the UPHP Member and Provider Handbooks. Information will also be provided in member and provider newsletters.

Procedure

To initiate continuity of care coverage, the member, his or her appointed representative, or the member's provider may submit the request by writing or calling:

Upper Peninsula Health Plan
Attn: Utilization Management
853 West Washington St.
Marquette, MI 49855
Phone: Toll Free 1-800-835-2556 (TTY: 711) or UM Direct Line 906-225-7774
Fax 906-225-9269

Or

by contacting their UPHP Care Coordinator

When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with UPHP. UPHP staff will assist and reach out to get any additional information that may be needed.

When UPHP receives an oral or written request, the request will be logged in Plexis Claims Manager (PCM) in a call tracking note as follows:

- Category: UTILIZATION
- Subject: MCAID TRANSITION OF CARE
- Status: ROUTED
- Owner: _CLINICAL MCAID TOC

Once the request has been documented and routed, the PCM note will also be emailed to MedicaidTOC@uphp.com. This will alert the UPHP ITC team of a continuity of care request. If the request comes in via a call, UPHP staff will also warm transfer to a UPHP ITC member if available. If staff unavailable at the time of the call, UPHP staff taking the call will verify contact information and document that in the PCM call tracking note.

The Clinical Coordinator-UM will review all oral/written requests and initiate the UM_ Medicaid Transition of Care Script in and outreach to the provider and/or member to discuss needed services, upcoming appointments and review CC360 to determine if other services/providers need to be authorized. The Clinical Coordinator-UM will assess the member's history and current medical, dental, behavioral health, and social needs. The UPHP Pharmacist will review and authorize any medications member was previously on and document findings/activities in Altruista.

For member's enrolled in special programs such as CSHCS or Benefits Monitoring Program (BMP), the Clinical Coordinator-UM will outreach to the designated Clinical Coordinators for those programs. If any social needs are identified during the assessment, the Clinical Coordinator-UM will refer the member to the UPHP Connected Communities for Health (CC4H) program where a CHW will assist the member.

For services that meet transition of care criteria, the Clinical Coordinator-UM- and/or UPHP Pharmacist will authorize services/medications for at least 90 days (this includes out-of-network providers). Services may be authorized for longer periods based on the member's clinical

condition. Standard transition of care requests will be processed within 3 business days while urgent requests will be processed within 72 hours of notification of the request. Decision notices will be communicated to both members and providers within these timeframes which will include details on services approved and approval timeframe. These notices will generated and sent out by the Clinical Coordinator-UM.

The Clinical Coordinator-UM will be responsible for ensuring transition of care activities have been completed and will close out the Transition of Care script in Altruista and note in PCM.

Once the transition of care period is over and the authorization has expired, the member and/or provider will request services through the UM process as described in UPHP Policy, *300-005 Utilization Management and 300-009 Pharmacy Prior Authorization Process.*

Maintenance of Transition of Care Authorization Records:

UPHP maintains a record of all medical authorization requests in the Plexis Claims Manager (PCM) system and pharmacy authorizations in the MagellanRx authorization system. These systems contain the following information:

- Member Name
- Medicaid ID number
- Request Type (standard or expedited)
- Date of original request
- Extension request
- Service code (if applicable)
- Diagnosis code
- Decision made
- Date of decision
- Date the member notice was sent, and if denied, the reason for denial.

Attachments

None

Exception to this policy may be made with the approval of the Chief Executive Officer or an authorized designee.

END OF POLICY & PROCEDURE