

# KanCare

## Transitional Care Requirements

### Introduction

The State of Kansas contracts with Managed Care Organizations (MCOs) to deliver care to Kansas Medicaid Enrollees, in a comprehensive and person-centered manner otherwise known as KanCare. One expectation of KanCare is that MCOs provide transitional care management as Enrollees' health care needs change and they move from one setting to another. To support this effort, the State has laid out expectations regarding transitional care management by MCOs for all KanCare Enrollees, based upon the Enrollees' needs. These expectations apply to all MCOs assigned to manage and coordinate care for Kansas Medicaid Enrollees. This guidance serves to clarify expectations for enrollee care management during times of transition, in compliance with State requirements as well as those of the Medicaid Managed Care Final Rule as specified within 42 CFR §438.62 and 42 CFR §438.208.

### MCO Transitional Care Management Requirements

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#### Definition

MCOs are required to provide transitional care management for all KanCare Enrollees. Transitional care management is specialized care coordination for Enrollees whose health care needs are changing, and is designed to facilitate transition of treatment plans from hospitals, emergency department (ED), and inpatient-enrollee units, to home, Long Term Services and Supports (LTSS) providers, rehabilitation facilities, and other health service systems, thereby interrupting patterns of frequent emergency department use, and reducing avoidable hospital stays. Transitional care is also required when Enrollees are moving from one MCO to another, moving from fee-for-service model to managed care, or moving from non-traditional settings, e.g., incarceration, into managed care. MCOs must ensure that transitional care occurs with minimal service disruption and with continuance of current provider(s) when possible.

Transitional care management involves the right amount of assistance, at the right time, and for the right duration, to assist KanCare Enrollees to receive health maintenance services that holistically meet their physical health, mental/behavioral health, and/or LTSS care needs in the least restrictive setting. Transitional care management may employ various levels of care coordination, e.g., management of a short term change in health, such as acute appendicitis, during which services are provided and then Enrollees return to their baseline of self-care, to management of severe and traumatic changes in Enrollees health status that require intensive transitional care management and LTSS.

## Eligibility

Every eligible KanCare enrollee may at some time require comprehensive transitional management of their care. The provision of transitional care must not exclusively focus on Enrollees already assigned to LTSS or Home and Community Based Services (HCBS) waiver; rather, transitional care should be provided to all Enrollees as the need arises. Enrollees, whether they are or are not receiving care coordination, may need transitional care in certain situations including, but not limited to, the following:

- Hospital (Ex: State hospital, ICF-IID, etc.) to nursing facility
- Hospital (Ex: State hospital, ICF-IID, etc.) to community
- Nursing facility to community
- Community to nursing facility
- Incarceration to community
- Enrollee assignment to HCBS waiver
- Enrollee assignment of chronic care management moved from one provider to another
- Transitioning from one MCO to another
- Transitioning from Fee-for-Service (FFS) to KanCare, e.g., members ages 22 to 64 leaving NFMHs
- Transitioning to or from KanCare eligibility
- Transitions for children in Foster Care

## Transitional Care Plan

Transitional care involves developing a transitional care plan with the Enrollee, family/support persons or guardians, and other providers, and transmitting the comprehensive transition/discharge plans to all involved. For each Enrollee transferred from one caregiver or site of care to another, the MCO should coordinate transitions, ensure proper and timely follow-up care, and provide medication information and reconciliation. Comprehensive transitional care may involve, but is not limited to the following:

- Collaboration, communication and coordination with Enrollees, families/support persons/guardians, hospital ED, LTSS, physicians, nurses, social workers, discharge planners, and service providers
  - This should include establishing a single point of contact for coordination efforts
- Easing transition by addressing the Enrollee's understanding of medications, self-management, rehabilitation activities, LTSS, employment, and independence.
- Scheduling appointments and reaching out if appointments are missed
- Evaluating the need to develop or revise the plan or care
  - This must include collaboration with and input from the member, caregivers, or other appropriate entities, with the member's permission
  - This should consider the caregiver's needs and provide connection to caregiver services, if needed

The transition/discharge plan includes, but is not limited to, the following elements:

- Timeframes related to appointments, discharge paperwork, and aftercare (behavioral supports)
- Follow-up appointment information
- Medication information to allow providers to reconcile medications and make informed decisions about care
- Medication education
- Therapy needs, e.g., occupational, physical, speech, etc.
- Transportation needs
- Community supports needed post-discharge
- Determination of environmental (home, community, workplace) safety

## Requirements for Specific Transitions

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### Transition Between MCOs

To ensure the continuity of care during periods of Enrollee transition between MCOs, the following actions must be taken:

- All MCOs must designate points of contact to aide in MCO-to-MCO outreach during these transitions.
- “Receiving” MCOs must make outreach to the previous MCO to gather Enrollee provider information and Plans of Care, as necessary.
- “Receiving” MCOs must utilize previous MCO encounter data provided by the State to determine previously utilized Enrollee providers and services.
- “Receiving” MCOs must develop or attempt to develop contracts with previously utilized providers to ensure the continuity of care for Enrollees.
  - MCOs must make efforts to preserve existing relationships between providers and Enrollees in which the provider was a main source of Medicaid services for the Enrollee during the previous year.
- “Receiving” MCOs must update all **relevant documentation and planning**.
- “Original” MCO will have 15 calendar days to provide the documentation.
- Ensure that the current Plan of Care in place with the ‘original’ MCO will be honored for 90 days by the ‘receiving’ MCO. Services should not change or reduce until after 90 days are over and the initial screening has occurred. This requirement may be waived at the Enrollee’s request. The MCO may include additional services at any time to benefit the Enrollee.
- Ensure that the current authorization in place with the ‘original’ MCO will be honored without change by the ‘receiving’ MCO until 90 days after the transfer of the enrollee. This requirement may be waived at the Enrollee’s request. The MCO may include

additional services at any time to benefit the Enrollee. This does not include patients who are being discharged from a facility. The inpatient authorization stops with the discharge.

- Enrollees are entitled to see an established PCP for six months after their transition, regardless if the provider is 'in network' or not.
- This policy timeframes takes precedence over the KanCare contract stipulations around needs assessment timeframes and Person Centered Service Plan timeframes for members who transfer from other MCOs and already have a plan of care associated with their waiver. If the member changes waivers OR is a new KanCare member, the contract timeframes apply.

### **Transition Between MCOs When 'Receiving' MCO Is New To KanCare**

For MCOs that are new to KanCare, there are additional requirements for the first ninety days of their contract with the State of Kansas:

- Providers who are already enrolled in KMAP and not yet contracted with the MCO will be paid as 'in network' at 100% of the Medicaid fee-for-service (FFS) rate through the first 90 days after the MCO enters the KanCare program. If the provider has applied for credentialing or contracting, and the MCO is not timely due to internal delays with their provider networking process, then the MCO must extend the period during which the provider is deemed 'in network'.
- Providers who are not yet contracted or credentialed with one or more MCOs do not need to prior-authorize every service during the KanCare transition. During the first 90 days for a new KanCare MCO, participating and non-participating providers alike should follow the plan's service prior authorization/notification policies for participating providers. Except as outlined in the paragraph above, at the end of the 90-day period, non-contracted providers must follow the MCOs regular non-contracted provider authorization procedures.

For all transitions specified above, MCOs must ensure that any sharing of Enrollee information is conducted with the consent of the Enrollee or designated representative and in accordance with State and Federal privacy requirements.

### **Fee for Service-to-MCO**

MCOs must ensure the continuity and continuation of care for Enrollees transitioning between Fee for Service (FFS) and managed care. An example of a FFS-to-MCO transition could include movement of an enrollee aged 22 to 64 from a NFMH to an MCO. To facilitate FFS-to-MCO transitions, MCOs should do the following:

- Utilize FFS claim data provided by the State to determine previously utilized Enrollee providers and services.

- Develop or attempt to develop contracts with previously utilized providers to ensure the continuity of care for Enrollees.
  - MCOs must make efforts to preserve existing relationships between providers and Enrollees in which the provider was a main source of Medicaid services for the Enrollee during the previous year.
- Update all pertinent documentation and planning to most effectively support the Enrollee post-transition.

## **Institutions of Incarceration and MCOs**

MCOs must cooperate with the justice systems in Kansas, to include but not limited to: Kansas Department of Corrections and county level institutions of incarceration. As part of this process, designated points of contact should be established between the MCO and the Department of Corrections, county jails, or other justice systems within the state to streamline the coordination of efforts.

## **Children in Foster Care**

MCOs must ensure the continuity and continuation of care for child Enrollees who are also in foster care. This care management should be provided to children transitioning into and out of foster care, as well as movement of foster care children from one MCO assignment to another, as applicable. In the latter case, MCOs should follow the specifications included in the above section entitled “Between MCOs”.

## **Leaving an MCO Assignment**

Enrollees may leave their MCO assignment with or without cause during the 90-day choice period following the initial enrollment and during the annual open enrollment period thereafter. Enrollees may choose to disenroll from their MCO assignment with good cause at any time in the following situations:

- Enrollee moves out of state
- Enrollee’s assigned plan does not, because of moral or religious objections, cover the service the Enrollee seeks
- The Enrollee needs related services (for example a caesarean section and a tubal ligation) to be performed at the same time but not all related services are available with the network, and the Enrollee’s PCP or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk
- For enrollees that use MLTSS, the Enrollee would have to change their residential, institutional, or employment supports provider based in that provider’s change in status from an in-network to an out-of-network provider with the MCO and, as a result, would experience a disruption in their residence or employment

- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the MCO's plan, or lack of access to providers experienced in dealing with the Member's health care needs

Additionally, Enrollees may leave an MCO assignment for the following reasons:

- Enrollee loses eligibility
- Enrollee is placed in an adult or juvenile correctional facility
- Enrollee selects another managed care plan during their annual open enrollment period
- Enrollee passes away
- Enrollee transfers to a Medicaid eligibility category outside of managed care
- To implement the decision of a hearing officer in a formal grievance procedure by the Enrollee against the MCO or by the MCO against the Enrollee

MCOs must ensure the continuity of care for Enrollees who are leaving their current assignment through the following actions:

- Referring the Enrollee to the KanCare Enrollment Center to process an Enrollee's disenrollment
- Transferring relevant Enrollee information, including medical records and other pertinent materials, when an Enrollee is assigned to another plan
- Transferring relevant Enrollee information, including medical records and other pertinent materials, when an Enrollee transitions out of KanCare and into another State-administered setting (e.g. incarceration, State hospital, etc.)
- Making relevant Enrollee information, including medical records and other pertinent materials, available to the Enrollee upon request

For all transitions specified above, MCOs must ensure that any sharing of Enrollee information is conducted with the consent of the Enrollee or designated representative and in accordance with State and Federal privacy requirements.