Policy Title: TRANSITION OF CARE	Policy Number: HI.QI.TRANSITION OF CARE.xx
Owner Department: QUEST Integration	Effective Date: 7/1/2021
Custodian: Senior Project Manager	Page: 1 of 6

1.0 Policy Statement

Kaiser Foundation Health Plan, Inc. (KFHP) will ensure that QUEST Integration (QI) members who are transitioning into KFHP's QI health plan or to a different QI health plan or insurer, will have access to, and obtain medically necessary health care services in a timely manner pursuant to the requirements of the QI RFP-MQD-2021-008 contract.

2.0 Purpose

The purpose of the Transition of Care Policy is to address all transition of care requirements in QI RFP-MQD-2021-008 RFP. This transition of care policy specifies the following:

1. Transitioning Members will continue to have access to services that were started under the former QI health plan and will be permitted to retain their current provider for a period of time if that provider is not in KFHP's provider network.
2. Transitioning Members will also be able to access services consistent with the access they previously had, at least for an initial period of time if the provider is not in Kaiser's provider network.
3. Transitioning Members will be referred to appropriate providers within KFHP's provider network.
4. A transitioning Member's previous provider(s) will fully and timely comply with requests for historical utilization data from Member's new provider(s) in compliance with Federal and State law.
5. A transitioning Member's new provider(s) will be able to obtain copies of their medical records consistent with Federal and State law, as appropriate.
6. Any other necessary procedures as specified by the Secretary of DHHS to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.
7. The transition of care policy will be publicly available on the Member website, https://kpquest.org and provide instructions to Members on how to access continued services upon transition.

3.0 Scope

This policy applies to:

- QI members transitioning from KFHP to a different Health Plan;
- QI members transitioning to KFHP from a different Health Plan;
- Kaiser Foundation Health Plan, Inc. (KFHP) staff.

4.0 Definitions/Acronyms

- Department of Health and Human Services (DHHS)
- Kaiser Foundation Health Plan, Inc. (KFHP)
- Med-QUEST Division (MQD)
- QUEST Integration (QI)
- State of Hawaii, Department of Human Services (DHS)
- Transitions of Care (TOC) – The movement of Members between healthcare practitioners, settings, and home as their conditions and care needs change. For example, a Member might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving to another care team at a SNF.

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5.0 Provisions

9.3.A. Transition to Different Health Plan

1. In the event a Member entering the Health Plan is receiving Covered Services that meet Medical Necessity in addition to or other than prenatal services, including Members in the second and third trimester of pregnancy receiving prenatal services described in this section, the day before enrollment into the Health Plan, the Health Plan shall be responsible for the costs of continuation of such services that meet Medical Necessity, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract Providers. Health Plans shall be responsible for services that meet Medical Necessity provided during prior period coverage and retroactive enrollment.
2. Health Plans shall ensure that during transition of care, its new Members:
    a. Receive all emergency services that based on Medical Necessity;
    b. Receive all prior authorized LTSS, including both HCBS and institutional services;
    c. Adhere to a Member's prescribed prior authorization for services that meet Medical Necessity requirements, including prescription drugs, or courses of treatment; and
    d. Provide for the cost of care associated with a Member transitioning to or from an institutional facility in accordance with the requirements prescribed in §9.2.A.
    e. The Health Plan shall provide continuation of services for individuals with SHCN or who are receiving LTSS for at least ninety (90) days or until the Member has received an assessment by the new Health Plan as described in Section 3.
    f. The Health Plan shall provide continuation of other services for all other Members for at least forty-five (45) days or until the Member's medical needs have been assessed or reassessed by the PCP who has authorized a course of treatment.
    g. The Health Plan shall reimburse PCP services that the Member may access during the forty-five (45) days prior to transition to their new PCP even if the former PCP is not in the network of the new Health Plan.
    h. In the event the Member entering the Health Plan is in her second or third trimester of pregnancy and is receiving covered prenatal services based on Medical Necessity the day before enrollment, the Health Plan shall be responsible for providing continued access to the prenatal care provider, whether contract or non-contract, through the postpartum period.

9.3.B. Transition from the Health Plan

1. If the Member moves to a different service area in the middle of the month and enrolls in a different Health Plan, the former Health Plan shall remain responsible for the care and the cost of the inpatient services, as provided in §9.2.A,

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provided to the Member, if hospitalized at the time of transition, until discharge or LOC changes, whichever occurs first. Otherwise, the new Health Plan shall be responsible for all services to the Member as of Member's date of enrollment. If the Member moves to a different service area and remains with the same Health Plan, the Health Plan shall remain responsible for the care and cost of the services provided to the Member.

2. The former Health Plan shall cooperate with the Member and the new Health Plan when notified in transitioning the care of a Member who is enrolling in a new Health Plan. The former Health Plan shall submit transition of care information to DHS utilizing a format specified by DHS for transition to the new Health Plan within five (5) business days of the former Health Plan being notified of the transition.
3. The former Health Plan shall ensure DHS or the new Health Plan has access to the Member's medical records and any other vital information that the former Health Plan has to facilitate transition of care.

9.3.C. Transition of Care Policies and Procedures

1. The Health Plan shall develop transition of care policies and procedures that address all transition of care requirements in this RFP and submit these policies and procedures for review and approval in accordance with §13.3.B. The transition of care policy shall be consistent with the requirements set forth below.
2. The transition of care policy shall include the following:
   a. The Member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the provider network;
   b. The Member is referred to appropriate providers of service that are in the new plan's provider network;
   c. The Member's previous provider(s) shall fully and timely comply with requests for historical utilization data from Member's new provider(s) in compliance with Federal and State law.
   d. The Member's new provider(s) shall be able to obtain copies of the Member's medical records consistent with Federal and State law, as appropriate.
   e. Any other necessary procedures as specified by the Secretary of DHHS to ensure continued access to services to prevent serious detriment to the Member's health or reduce the risk of hospitalization or institutionalization.
   f. The transition of care policy shall be publicly available and provide instructions to Members on how to access continued services upon transition.

6.0 Maintenance

Include This policy shall be reviewed at least every three (3) years, and revised periodically, to assure continuing relevance and compliance with regulatory and accrediting standards, hospital bylaws, rules and regulations, and legal statutes.

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7.0 References/Appendices

- QI-1714 Transition of Care – Clarification of Financial Responsibility Roles
- Appendix A – Transition of Care Process - Annual
- Appendix B –Transition of Care Process -Throughout the Year

8.0 Hawaii Endorsement and Approval:

Contact Person:	Michele Nishimoto-Souza, Senior Project Manager, QI Administration	
Reviewed by:	Jessica Gouvea, Senior Consultant, QI Administration	Date: 5/14/2021
Approved by:	Cathy Makishima, Director QUEST Integration Member Services & Administration	Date: 5/14/2021
Last Review:	5/14/2021	
Next Review:	5/14/2024	
Replaces	Name and date of policy that is being archived or retired.	

Policy Life History

Action[1]	Approval	Effective
Original	5/14/2021	7/1/2021

[1] Update = No material change to the policy content, policy is reviewed and renewed with no, or non-material changes. Revision = Material change is included in the renewed policy.

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Appendix A – Transition of Care Process - Annual

1. The Med-QUEST Division (MQD), Health Care Services Branch (HCSB) issues a memo annually for all members transferring to a new health plan effective January 1 of the following year.
2. MQD serves as the Transition of Care (TOC) data intermediary, between the Ql plans submitting and receiving the TOC information. The selection of a new QI health plan at open enrollment is effective January 1.
3. MQD provides five TOC data file attachments and specifications to the Ql health plans. for the following categories:
    a. Member Demographics
    b. Paid Medical Claims
    c. Paid Pharmacy Claims
    d. Medical Referrals
    e. Prior Authorizations
4. MQD sends a list of Members leaving and enrolling into the Ql plan.
5. KFHP retrieves the necessary TOC data and completes the five attachments for Members leaving KFHP.
6. KFHP uploads the required data in the attachments to KFHP's folder on MQD's SFTP site under the 'other/HP Reports/folder'.
7. MQD retrieves the data from the SFTP site and sends the TOC data in the attachments to the respective receiving QI plan.
8. KFHP receives the new member data and coordinates with staff to ensure that Members who were receiving medically necessary covered services the day before enrollment into KFHP, continue to receive these services without prior approval and without regard to whether such services are being provided by contract or non-contract providers. KFHP ensures that during transition of care, new members:
    - Receive all medically necessary emergency services
    - Receive all prior authorized long-term services and supports (LTSS), including both Home and Community Based Services (HCBS) and institutional services
    - Adhere to a member's prescribed prior authorization for medically necessary services. including prescription drugs, or other courses of treatment
    - Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in QI RFP.

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Appendix B –Transition of Care Process -Throughout the Year

1. KFHP receives TOC requests throughout the year for Members transition to another QI plan and coordinates with staff to ensure that the necessary information is provided to the requesting QI plan.
2. Members who were receiving medically necessary covered services the day before enrollment into KFHP, continues to receive services without prior approval and without regard to whether such services are being provided by contract or non-contract providers. KFHP ensures that during transition of care, new members:
   - Receive all medically necessary emergency services
   - Receive all prior authorized long-term services and supports (LTSS), including both Home and Community Based Services (HCBS) and institutional services
   - Adhere to a member's prescribed prior authorization for medically necessary services. including prescription drugs, or other courses of treatment
   - Provide for the cost of care associated with a member transitioning to or from an institutional facility in accordance with the requirements prescribed in QI RFP.

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