



## Troy Medicare Policy and Procedure

<b>Title:</b> Transition of Care Policy			<b>Policy Number:</b> CM-002	
<b>Primary Department:</b> Care Management		<b>LOB:</b> Medicare Advantage		<b>Author:</b> Ileana Havrilla and Hannah Beal
<b>Effective Date:</b> 10/28/2022	<b>Original Date:</b> 10/27/2022	<b>Review Date(s):</b>		<b>Archive Date:</b>
<b>Interactive Related Department(s)</b>				
<input type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input type="checkbox"/> Medical Management <input type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing		<input type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Pharmacy <input type="checkbox"/> Member Services <input type="checkbox"/> Quality Management <input checked="" type="checkbox"/> Utilization Management		<input checked="" type="checkbox"/> Care Management <input type="checkbox"/> Enrollment <input type="checkbox"/> Plan Administration <input type="checkbox"/> Claims <input type="checkbox"/> Other _____

### POLICY PURPOSE

Troy Health, Inc. is committed to complying with CMS regulations regarding Transitions of Care for dual-eligible Special Needs Plan (SNP) members.

The purpose of this policy is to outline the guidelines for Care Management and Utilization Management to ensure safe care setting transitions for all SNP members in accordance with the standards set forth by the Centers for Medicare and Medicaid Services (CMS). Care Management and Utilization Management must have a protocol in place for maintaining continuity of care for members experiencing a care transition and the process for sharing ICP information between health care settings.

### SCOPE

This policy applies to all employees in Utilization Management and Care Management at Troy.

### REFERENCES

- 42 CFR §422.101(f)(1); 42 CFR §422.152(g)(2)(iv)
- Medicare Managed Care Manual Chapter 5, Section 20.2.1
- [Model of Care Scoring Guidelines for Contract Year 2023](#)

### RESPONSIBLE PARTIES

- Vice President of Health Services
- Chief Medical Officer

## DEFINITIONS

**Continuity of Care (COC)-** Continuity of care is an approach to ensure that the patient-centered care team is cooperatively involved in ongoing healthcare management toward a shared goal of high-quality medical care. Continuity of care promotes patient safety and assures quality of care over time.

**Individualized Care Plan (ICP)-** the member plan that includes health goals, barriers, and interventions based on HRA results

**Transition-of-Care (TOC)-** refers to the movement of a member from one care setting to another as the member's health status changes. A transition-of-care plan will encompass the member's movement from home to hospital, hospital to rehabilitation facility, as well as hospital or rehabilitation facility to home.

**Post Discharge Assessment-** an assessment completed by the Care Manager to determine a member's needs after being discharged from an inpatient setting to home.

**Post Discharge Attempt Cycle-** 3 outreach attempts to reach the member after discharge from the hospital to home.

## POLICY

CMS regulations require all SNPs to develop and implement transition of care (TOC) protocols. TOC protocols must include the following factors:

- The plan must explain how care transitions protocols are used to maintain continuity of care for SNP beneficiaries. Provide details and specify the process and rationale for connecting the beneficiary to the appropriate provider(s).
- The plan must describe which personnel (e.g., case manager) are responsible for coordinating the care transition process and ensuring that follow-up services and appointments are scheduled and performed as defined in MOC Element 2A.
- The plan must explain how the SNP ensures elements of the beneficiary's ICP are transferred between healthcare settings when the beneficiary experiences an applicable transition in care. This must include the steps that need to take place before, during and after a transition in care has occurred.
- The plan must describe, in detail, the process for ensuring the SNP beneficiary and/or caregiver(s) have access to and can adequately utilize the beneficiaries' personal health information to facilitate communication between the SNP beneficiary and/or their caregiver(s) with healthcare providers in other healthcare settings and/or health specialists outside their primary care network.
- The plan must describe how the beneficiary and/or caregiver(s) will be educated about indicators that his/her condition has improved or worsened and how they will demonstrate their understanding of those indicators and appropriate self-management activities.

- The plan must describe how the beneficiary and/or caregiver(s) are informed about who their point of contact is throughout the transition process.

## PROCEDURE

### Transition of Care

1. The Utilization Management (UM) Nurse is alerted to a SNP member being admitted to a hospital or rehab facility when a request for authorization comes through
2. After being alerted of admission, the Utilization Management Nurse facilitates the authorization and sends authorization approval to member, facility, and provider.
3. Care Managers are notified of SNP member admissions and discharges during weekly UM/CM rounds. Barriers to discharge and any other pertinent member information are also shared during these rounds to ensure continuity of care is maintained for DSNP members.
4. Within 2 business days of being notified that a SNP member has been admitted, the Care Manager contacts the receiving facility to share the Care Plan and their contact information for discharge planning. The ICP will be shared with appropriate care team member (i.e., the Primary Nurse, Social Worker, or Case Manager), depending on the inpatient setting the member is in.
5. The Care Manager will then document in TruChart that the Care Plan was shared with the member's receiving inpatient setting, including documentation of the facility's employee that the Care Manager spoke with. If the member has already been discharged and sharing of the care plan is not able to be completed, this will be documented as well.
6. If the Care Manager is notified of the members transition to another level of care, they will place a call to share the ICP elements with the receiving setting and offer contact information for discharge planning and document in TruChart upon completion. The UM Nurse works with the facilities Care Management team to complete authorization approval in the event of a transfer to another level of care.
7. Within 2 business days of receiving notice of discharge to usual setting during UM/CM rounds, the Care Manager will initiate the Post Discharge Attempt Cycle with the member to complete all the Transition of Care requirements. All outreach attempts to the member, and the TOC work must be completed within 2 weeks of notification that a member has been discharged.
8. If the member is reached during the first contact attempt of the Post Discharge Attempt Cycle, the Care Manager completes the following steps.
  - a. The Care Manager will review the member's discharge instructions (if available), their medication list, and any discharge barriers, and will complete the post discharge assessment, educate the member on their health condition, and how to identify symptoms that indicate improved or worsened health status.

- b. If it has been longer than 90 days since the last HRA, the Care Manager will complete an HRA with the member.
  - c. Next, the Care Manager will update the ICP to reflect needs identified on the Post Discharge Assessment, and any needs identified on the HRA (if the previous HRA was completed greater than 90 days ago.)
  - d. The Care Manager will start any needed referrals to the Troy dietitian or Social Worker as well as coordinate care for the member with their care team (PCP, Specialists, Home Health, DME Provider, etc.).
  - e. The Care Manager will document in TruChart the information in a note titled "Transition of Care."
9. If the member is not able to be reached during the first phone call attempt the Discharge the Care Manager will follow the unable to reach process.

**APPROVALS**



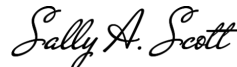
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**Chief Medical Officer**

10 / 28 / 2022

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**Date:**



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**Committee Approval**

10 / 28 / 2022

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**Date:**