COLORADO
Department of Health Care Policy & Financing

Updated February 26, 2020

Transition of Care Policy

Per 42 CFR 438.62, the Department of Health Care Policy and Financing (Department) must have in effect a transition of care policy to ensure members with special health care needs have continued access to services during a transition from fee-for-service (FFS) or from one Managed Care Entity (MCE) to another MCE.

Members, who in the absence of continued services, would suffer serious detriment to their health, or be at risk of hospitalization or institutionalization, including all members known as pregnant for up to sixty days post-partum, are considered as having special health care needs. The Department must require its MCEs to implement a transition of care policy that is consistent with federal regulations and that, at least, meets the requirements stipulated below.

When a member leaves an MCE or FFS

It is the Department's policy that when a member who would suffer serious detriment to their health or be at risk of hospitalization or institutionalization leaves an MCE or FFS, the MCE or State, respectively, must:

- Identify the member(s) and notify the receiving MCE about the incoming member(s).
- Coordinate care and share care coordination information upon request.
- Make referrals to appropriate network and out-of-network providers if necessary.
- Assist in transferring appropriate clinical information (including, but not limited to, medical records, care plans and care coordination records) between the old and new providers. These records shall be transferred within 7 business days in a manner consistent with federal and state laws.

For the Receiving MCE

It is the Department's policy that when a member with special health care needs joins a new MCE, the receiving MCE must:

- Coordinate care and develop a new care plan as appropriate.
- Honor current courses of treatment, as authorized, without additional authorization at a rate negotiated in good faith for a minimum of sixty (60) days, even if the provider does not participate in the MCE's network. If necessary, this includes single-case agreements or paying out-of-network providers for any ongoing course of treatment. MCEs may require a continued stay authorization, to determine that a previous course of treatment remains medically necessary after an initial authorization expires.