5. Transitions of Care

5.1. General Information

In managed care, ~~HSD~~HCA will continue its commitment to providing the necessary supports to assist ~~m~~Members as they transition under various circumstances.

The MCOs must identify and facilitate coordination of care for all ~~m~~Members during various transitions including but not limited to:

- Transition from an NF to the community;
- Transition for ~~m~~Member(s) with special circumstances;
- Transition for ~~m~~Member(s) moving from a higher LOC to a lower LOC;
- Transition for ~~m~~Member(s) turning 21 years of age;
- Transition for ~~m~~Member(s) changing MCOs while hospitalized;
- Transition for ~~m~~Member(s) changing MCOs during major organ and tissue transplantation services;
- Transition for ~~m~~Member(s) changing MCOs while receiving outpatient treatment for significant medical conditions;
- Transition for ~~m~~Member(s) changing MCOs;
- Transition for ~~m~~Member(s) previously in FFS;
- Transition for ~~m~~Member(s) moving from a residential placement or institutional facility (including psychiatric hospitals) to a community placement;
- Transition for children entering or returning home from a foster care placement;
- Transition for ~~m~~Member(s) released from correctional institutions, including juvenile or adult prisons, jail ~~incarceration or detention~~or detention center facilities;
- Transition for ~~m~~Member(s) moving from an out-of-state placement to an in-state placement;
- Transition from ARTC or RTC to TFC, group home or foster care.
- Transition for ~~m~~Member(s) discharging from a hospital;
- Transition for ~~m~~Member(s) discharging from out-of-home placements (ARTC, RTC, Group Home, Therapeutic Foster Care [TFC]) and crisis centers related to BH treatment; and/or
- Transition for ~~m~~Member(s) who are preparing to receive out-of-state treatment.

5.2. Transitions of Care

The MCOs shall develop and implement methods for identifying and facilitating ~~c~~Care ~~c~~Coordination for all ~~m~~Members involved in various transition scenarios. Such methods shall include, at a minimum:

- The CNA;
- Preadmission Screening and Resident Review (PASRR);
- MDS;
- Provider referrals to or from hospitals and RTCs;
- Ombudsman;
- Family M~~m~~ember;
- Change in medical status;
- Member self-referral;
- Community Reintegration Allocation received;
- A recommendation from the Individualized Planning Meeting Plan for a child or youth in CYFD PS custody or CYFD JJS;
- State Agency Referral; and/or
- Incarceration or detention facility referral.

If a ~~m~~Member is a candidate for transitioning to the community, the ~~C~~care ~~C~~coordinator shall facilitate the development of and implementation of HCA's standardized TOC Plan (See Appendix 5.14.1).~~a transition plan which must be labeled "Transition of Care Plan" and may be a stand-alone document or included in the CCP. If included as a part of the CCP, t~~The "~~Transition of Care Plan~~"~~ must be clearly labeled for MCO tracking and ~~HSD~~HCA auditing. The ~~t~~Transition of ~~c~~Care ~~p~~Plan shall remain in place for a minimum of 60 calendar days from the date of the decision to pursue transition or until the transition has occurred and a new CCP is in place.

~~The transition of care plan shall address the member's transitional needs including but not limited to:~~

- ~~PH and BH needs;~~
- ~~CB needs;~~
- ~~Continuation of Medicaid eligibility;~~
- ~~Selection of providers in the community;~~
- ~~Housing needs;~~
- ~~Financial needs;~~

- ~~Interpersonal skills (the social skills people use to interact effectively with other people, including the ability to convey one's needs); and~~
- ~~Safety.~~

The ~~C~~care ~~C~~coordinator shall conduct an additional assessment within 75 calendar days after the transition to determine if the transition was successful and to identify any remaining needs resulting in a new CCP or modifications to an existing CCP.

If the ~~m~~Member has an existing full Medicaid category of assistance, other than Institutional Care, an allocation is not needed to reintegrate into the community. The reintegration process can be completed and CBs can be provided with the full Medicaid category.

If the Member is Not Otherwise Medicaid Eligible (NOME), and in an NF and wishes to receive services in the community, a Community Reintegration (CRI) allocation must be requested by contacting the Aging and Long-Term Services Department, Aging and Disability Resource Center (ALTSD/ADRC), prior to discharge (see Section 7: Community Benefits). The care coordinator must assist the Member in gaining eligibility for a CB category of assistance, and ensure services are authorized and in place for a safe and seamless discharge.

5.3. Transitions of Care Requirements

The MCO shall establish policies and procedures to ensure all ~~m~~Members are contacted in a timely manner and are appropriately assessed using ~~HSD~~HCA prescribed time frames, processes and tools, to identify needs.

The MCO shall coordinate with the discharge planning teams at hospitals and institutions (e.g., NFs, jails/prisons, juvenile detention centers and CYFD secure facilities, RTCs, psychiatric hospitals, behavioral health facilities) to address at a minimum:

- Need for HCBS;
- Follow up appointments;
- Therapies and treatments;
- Medications; and~~/or~~
- DME.

The MCO shall notify the assigned CYFD ~~p~~Permanency ~~placement~~ Planning ~~w~~Worker (PPW) for protective services (PS) involved children and youth and ~~j~~Juvenile ~~p~~Probation ~~o~~Officer (JPO) for juvenile justice -involved youth, and ~~c~~Community ~~b~~Behavioral ~~h~~Health ~~c~~Clinician (CBHC) within 30 Business Days

prior to transition in care for CYFD -involved children/youth. Precipitous discharge from these placements is prohibited.

The MCO shall perform an in-home- assessment for ~~m~~Members who are transitioning from an inpatient hospital, and may be in need of Community Benefits, or NF stay within three calendar days after the transition. The assessment will address at a minimum:

- Safety in home environment;
- PH needs;
- BH needs;
- Housing needs;
- Continuation of Medicaid eligibility;
- Financial needs;
- CNA if one is not in place; and
- CB needs and services in place.

The MCO shall contact the ~~m~~Member monthly for three months to ensure continuity of care has occurred and the ~~m~~Member's needs are met. The MCO shall not transition ~~m~~Members to another provider for continuing services unless the current provider is not a contract provider. The MCO shall facilitate a seamless transition to new services and/or providers, without any disruption in services as outlined in the CCP.

For ~~m~~Members who are preparing to receive out-of-~~-~~state treatment, the MCO shall ensure daily updates are provided to- the ~~m~~Member and/or Authorized Representative about the status of the out-of-~~-~~st~~-~~ate provider agreement and authorized treatment plan until treatment begins.

The MCO shall maintain active communication with the ~~m~~Member and/or AR once out-of-~~--~~-state treatment begins, including weekends and holidays, for the duration of the treatment. The MCO shall resume ~~c~~Care ~~c~~Coordination activities pursuant to 4.4 of the Agreement following treatment completion and ~~m~~Member's return to New Mexico.

5.4. Transition of Care Requirements for Pregnant Women

In the event a ~~member~~Member enrolling with an MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment in the MCO, the MCO shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period, without any form of prior approval.

In the event a ~~member~~Member enrolled with an MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment, the MCO shall be responsible for the costs related to the continuation of such medically necessary prenatal care services. This includes the delivery, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider. This coverage is required for up to 60 calendar days from the ~~member~~Member's enrollment or until the ~~member~~Member may be reasonably transferred to a contract provider without disruption in care, whichever is less.

If the ~~member~~Member is receiving services from a contract provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period.

If the ~~member~~Member is receiving services from a non-contract provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the MCO can reasonably transfer the ~~member~~Member to a contract provider without impeding service delivery that might be harmful to the ~~member~~Member's health in accordance with Section 4.4.16.3 of the Agreement.

5.5. Transfer from the Health Insurance Exchange

The MCO must minimize disruption of care and ensure uninterrupted access to medically necessary services for individuals transitioning between Medicaid and qualified MCO coverage on the Health Insurance Exchange.

At a minimum, the MCO shall establish transition guidelines for the following individuals:

- Pregnant women;
- Individuals with significant health care needs or complex medical conditions;
- Individuals receiving ongoing services or who are hospitalized at the time of transition; and
- Individuals who received prior authorization for services from its qualified MCO.

The MCO is expected to coordinate services and provide phase in and phaseout time periods for each of these individuals, and to maintain written policies, procedures, and documentation to address coverage transitions.

5.6. Transitions of Care for Members Moving from a Higher LOC to a Lower LOC

The MCO shall develop and implement policies and procedures for ensuring that ~~m~~Members transition successfully from higher levels of care (e.g., acute inpatient, residential treatment centers, social detoxification programs, treatment foster care, etc.) to the most appropriate lower LOC. Transitions from inpatient and BH residential treatment facilities for both children and adults must be addressed. At a minimum, the following must be addressed:

- Maintain ongoing communication, enlist the involvement of and coordinate with state-run facilities to monitor and support their participation in the ~~m~~Member's care.
- Care ~~C~~coordinators must be knowledgeable of non-Medicaid BH and PH programs/services, statewide, available to its ~~m~~Members in order to facilitate referrals, coordinate care, and ensure transition to community-based services.
- Ensure ~~m~~Members receive follow-up care within seven calendar days of discharge from a higher LOC to a lower LOC but receive follow up care no longer than 30 calendar days following other discharges.

5.7. Transitions of Members Turning 21 Years of Age

All ~~m~~Members, including those who are under the care of EPSDT, must be transitioned to other services on their 21st birthday. The c~~C~~are ~~C~~coordinator must initiate a transition plan by the age of 20 years, which is ongoing until the ~~m~~Member leaves the EPSDT program. The transition plan must be labeled "Transition of Care Plan" and may be a stand-alone document or included in the CCP. If included as part of the CCP, the "Transition of Care Plan" must be clearly labeled for MCO tracking and ~~HSD~~HCA auditing. The transition plan must:

- Establish a plan that is age appropriate and addresses the transition needs of the ~~m~~Member:
  - Health condition management;
  - Developmental and functional independence;
  - Education;
  - Social and emotional health;
  - Continuity of behavioral health services, if requested;
  - Guardianship; and
  - Transportation.

- Ensure ~~m~~Members and, when authorized, family ~~member~~Members, guardians and PCPs are part of the development and implementation of the transition plan. The MCO shall also ensure that the assigned CYFD ~~p~~Permanency ~~placement~~ Planning ~~w~~Worker (PPW) and/or youth transition specialist for Protective Services (PS) involved children and youth, ~~j~~Juvenile ~~p~~Probation ~~o~~Officer (JPO) or transition coordinator for juvenile justice involved youth, and ~~c~~Community ~~b~~Behavioral ~~h~~Health ~~c~~Clinician (CBHC) for CYFD involved children/youth are part of the development and implementation of the transition plan for CYFD involved children/youth.
- Document the transition plan in the medical record.
- Provide the ~~m~~Member, and when authorized, family members and guardian with a copy of the transition plan.
- Establish a timeline for completing all services the ~~m~~Member should receive through EPSDT prior to his or her 21st birthday.
- Review and update the plan and timeline with the ~~m~~Member, and when authorized, the guardian and family prior to official transition to adult provider.
- Advise the ~~m~~Member's PCP of the discharge and ensure coordination of the services with the adult PCP.

5.8. Transition for Members changing MCOs while Hospitalized

The MCO will make provisions for the smooth transition of care for ~~m~~Members who are hospitalized on the day of an enrollment change. The provisions must include policies for the following:

- Authorization of treatment by the receiving MCO on an individualized basis. The receiving MCO must address contracting for continued treatment with the institution on a negotiated fee basis, as appropriate.
- Notification to the hospital and attending physician of the transition by the relinquishing MCO. The relinquishing MCO must notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving MCO for authorization of continued services. If the relinquishing MCO fails to provide notification to the hospital and the attending physician relative to the transitioning ~~m~~Member, the relinquishing MCO will be responsible for coverage of services rendered to the hospitalized ~~m~~Member for up to 30 calendar days. This includes, but is not limited to, elective surgeries for which the relinquishing MCO issued prior authorization.

- Coordination with providers regarding activities relevant to concurrent review and discharge planning must be addressed by the receiving MCO, along with the mechanism for notification regarding pending discharge.
- Transfer of care to a physician and/or hospital affiliated with the receiving MCO. Transfers from an out of network provider to one of the receiving MCO providers cannot be made if harmful to the ~~m~~Member's health and must be determined medically appropriate. The transfer may not be initiated without approval from the relinquishing MCO PCP, or the receiving MCO Medical Director.

Note: Members in Critical Care Units, Intensive Care Units, and Neonatal Intensive Care Units require close consultation between the attending physician and the receiving MCO physician. If a ~~m~~Member is admitted to an inpatient facility while still assigned to the relinquishing MCO, and discharged after transition to the receiving MCO, both must work together to coordinate discharge activities.

The relinquishing MCO will be responsible for coordination with the receiving MCO regarding each specific prior authorized service. For ~~m~~Members known to be transitioning, the relinquishing MCO will not authorize hospital services such as elective surgeries scheduled less than 15 calendar days prior to enrollment with the receiving MCO. If authorized to be provided during this time frame, the service for the transitioning ~~m~~Member will be the financial responsibility of the MCO who authorized the service.

5.9. Transition for Members Changing MCOs during Major Organ and Tissue Transplantation Services

If there is a change in MCO enrollment, both the relinquishing and receiving MCOs will be responsible for coordination of care and coverage for ~~m~~Members awaiting major organ or tissue transplantation from the time of transplantation evaluation and determination through follow-up care after the transplantation surgery. If a ~~m~~Member changes MCO enrollment while undergoing transplantation at a contracted transplant center, the relinquishing MCO is responsible for contracted components or modules of the service up to and including completion of the service modules that the ~~m~~Member is receiving at the time of the change. The receiving MCO is responsible for the remainder of the module components of the transplantation service.

If a ~~m~~Member changes to a different MCO while undergoing transplantation at a transplant center that is not a contracted provider, each MCO is responsible for its respective dates of service (DOS). If the relinquishing MCO has negotiated a special rate, it is the responsibility of the receiving MCO to coordinate the continuation of the special rate with the respective transplant center.

5.10. Transition for Members Changing MCOs while receiving Outpatient Treatment for Significant Medical Conditions

MCOs must have protocols for ongoing care of active and/or chronic "high risk" (e.g., outpatient chemotherapy, home dialysis, etc.) ~~m~~Members and pregnant ~~m~~Members during the transition period. The receiving MCO must have protocols to address the timely transition of the ~~m~~Member from the relinquishing PCP to the receiving PCP, in order to maintain continuity of care.

The receiving MCO must address methods to continue the ~~m~~Member's care, such as contracting on a negotiated rate basis with the ~~m~~Member's current provider(s) and/or assisting ~~m~~Members and providing instructions regarding their transfer to providers affiliated with the receiving MCO.

Receiving MCOs are also responsible for coordinating the transition of pregnant women to maintain continuity of care. Pregnant women who transition to a new MCO within the last trimester of their expected date of delivery must be allowed the option of continuing to receive services from their established physician and anticipated delivery site.

~~1~~

5.11. MCO Requirements for Members Transitioning between MCOs

For any ~~m~~Member transitioning from one MCO to another the following must occur.

- ~~The relinquishing MCO must provide relevant information regarding Members who transition to a receiving MCO, including but not limited to, the Member file, within 5 business days of CARA or CISC Member transitions and within 10 business days for all other Member transitions. The relinquishing MCO must provide relevant information regarding mMembers who transition to a receiving MCO.~~
- The MCO must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of ~~m~~Members, subcontractors, or other providers, as appropriate during times of transition.
- The receiving MCO must provide new ~~m~~Members with their handbook and emergency numbers within 10 calendar days of transition for acute care ~~m~~Members and within 12 calendar days of transition for all other ~~m~~Members (allows for ~~c~~Care ~~c~~Coordination onsite visit).
- If a ~~m~~Member is referred to and approved for enrollment, the relinquishing MCO must coordinate the transition with the receiving MCO to ensure applicable protocols are followed for any special circumstances of the ~~m~~Member, and that continuity and quality of care is maintained during and after the transition.

- The relinquishing MCO that fails to notify the receiving MCO of transitioning ~~m~~Members with special circumstances, or fails to send the transition notification, will be responsible for covering the ~~m~~Member's care resulting from the lack of notification, for up to 30 calendar days.
- The MCO shall ensure that any ~~m~~Member entering the MCO 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 contracted with the MCO.

5.12 Transitions of Care for Justice Involved Members

The MCO shall develop and implement policies and procedures for ensuring that ~~m~~Members released from incarceration or detention facilities transition successfully back into the community. At a minimum, MCOs must:

• Initiate ~~an~~ the ~~HSD~~HCA ~~approved~~ MAD 900 JUST Health APHRA Transition of Care (TOC) assessment with the ~~m~~Member prior to ~~m~~Member's release or within three (3) business days of notification of ~~m~~Member's release.

• ~~Develop a TOC plan, derived from the TOC assessment, with mMember and/or mMember's representative's participation, that addresses, at a minimum:~~

~~Physical and Behavioral Health needs;~~

~~Community Benefit needs;~~

~~Selection of Providers in the community;~~

~~Housing needs;~~

~~Financial needs;~~

~~Continuation of Medicaid eligibility~~

~~Interpersonal skills; and~~

~~Safety~~

The Transition of Care ~~p~~Plan, within the MAD 900 JUST Health APHRA, shall remain in place for a minimum of sixty (60) calendar days from the ~~m~~Member's release or sixty (60) calendar days from notification of ~~m~~Member's release.

~~• Conduct a Health Risk Assessment (HRA) within three (3) business days of mMember's release or three (3) business days of notification of mMember's release unless the mMember has had one within the past thirty (30) calendar days.~~

• ~~Complete~~Initiate a Comprehensive Needs Assessment (CNA), within thirty (30) business days of ~~m~~Member's release or within thirty (30) business days of notification of ~~m~~Member's release. The CNA may be completed over the course of four appointments but must be completed within 90 days of the Member's release or MCO notification of Member's release. ~~, if warranted by the completed HRA~~APHRA~~, to determine if the m~~Member ~~should be assigned to Care Coordination l~~Level 1~~two (2) or l~~level three (3).~~2.~~

• ~~If the m~~Member ~~is leveled at CCL1~~2 ~~or CCL2~~3~~, f~~Follow all contract requirements for ongoing ~~c~~Care ~~c~~Coordination including development of a Comprehensive Care Plan, utilizing information from the completed MAD 900 JUST Health APHRA and CNA, and required touchpoints pursuant to the Medicaid Managed Care Services Agreement 4.4.

• Contact the ~~m~~Member monthly for three (3) months after ~~m~~Member's release to ensure continuity of care has occurred and that the ~~m~~Member's needs, identified in the MAD 900 JUST Health APHRA, have been met.

~~• Conduct an additional assessment within seventy-five (75) calendar days of m~~Member~~'s release to determine if the transition was successful and identify any remaining or ongoing needs.~~

5.13 Transitions of Care for Substance Exposed infants

The MCO shall develop and implement policies and procedures to ensure care coordinators assist in addressing the needs of pregnant mothers and fathers with opioid use disorders and their infants. Once the ~~member~~ Member is referred to the MCO by DOH or a hospital, the MCO care coordinator will be responsible for assessing, referring, and coordinating support services identified in the Comprehensive Addiction and Recovery Act (CARA) Plan of Care (POC)~~Plan of Care~~. MCO care coordinators are responsible for collaborating and coordinating care for the infant, affected mother/father and family and caregivers in accordance with the Children, Youth and Families Department (CYFD).

At a minimum, MCOs are responsible for:

- Providing annual training for ~~care~~ Care ~~coordination~~ Coordination staff on the Comprehensive Addiction and Recovery Act (CARA) Plan of Care (POC) to address the needs of both the pregnant women with opioid use disorders and their substance-exposed newborns. Training to include the difference between CYFD notification and CYFD referral or report;
- Coordinating care with the CYFD case worker, in cases where a child protective services case is determined necessary;

- Ensuring ~~care~~ Care ~~coordination~~ Coordination staff communicate and collaborate with hospital staff on implementation of the POC;
- Obtaining a copy of the POC from the hospital discharge planner;
- Ensuring MCO ~~care~~ Care ~~coordination~~ Coordination staff introduce support service providers identified in the POC to the infant and mothers including family and caregivers;
- Conducting a Health Risk Assessment (HRA) with the substance abuse-exposed infant inpatient whenever possible, and if not, within 24 hours after discharge from the hospital. ~~Conducting a Health Risk Assessment (HRA) with the substance abuse-exposed infant, parent or caregiver within twenty four (24) hours of notification of discharge from the hospital; three (3) Business Days of referral to the MCO~~;
- Completing a Comprehensive Needs Assessment (CNA) in the Member's home within seven (7) days of discharge to determine if the Member(s) should be assigned to Care Coordination Level One (CCL1) or Care Coordination Level Two (CCL2); ~~Completing a Comprehensive Needs Assessment (CNA), within seven (7) days of first contact thirty (30) Business Days of HRA completion to determine if the memberMember(s) should be assigned to Care Coordination level Level two One (CCL2CCL1) or level Level three Two (CCL3CCL2);~~
- Following all contract requirements for ongoing ~~care~~ Care ~~coordination~~ Coordination for ~~member~~Member(s) leveled at ~~CCL2~~ CCL1 or ~~CCL3~~CCL2, including development of a Comprehensive Care Plan (CCP) and required touchpoints pursuant to section 4.4 of the Medicaid Managed Care Services Agreement and sections 5.2 and 5.3 of the Managed Care Policy Manual; including but not limited to home visitation programs, early intervention services and recovery supports. MCOs should refer to contract requirements detailed in sections 4.4.6 and 4.4.7 that include, but are not limited to, high risk pregnancy and co-morbid health conditions as ~~CCL2~~ CCL1 and medically complex and/or untreated substance abuse dependency as ~~CCL3~~CCL2; and
- Notifying CYFD if the mother and/or family/caregiver(s) are Unable to be Reached, Difficult to Engage, Refuse Care Coordination~~, or are non-compliant with the POC and the CCP~~.

5.14 Appendix

5.14.1 MAD 868 HCA Standardized TOC Assessment

TURQUOISECARE

Health Care Authority (HCA)
Transition of Care (TOC) Assessment/Plan

1. Demographic Information			
Member's Name (First, Middle, Last)		**Date of Birth**	**Medicaid ID**
Date of MCO Notification of Transition	**TOC Plan Start Date**	**Transition Date**	**TOC Plan Completion Date**

Member's Address Prior to Transition **Street:** **City:** **State/Zip:**	**Member's Telephone** **Cell:** **Home:** **Other:**
Email Address	**Preferred Method of Contact** ☐Voice ☐Text ☐Mail ☐Email

Name of Emergency Contact	**Phone**	**Relation to Member**
Medicaid Eligibility Begin date	**Medicaid Eligibility Renewal Date**	

The CISC PC contact information will only be completed/populated into the TOC plan provided for CISC Members.

For Children in State Custody (CISC) Members (if applicable):	
Permanency Coordinator (PC) Name	**PC Phone**

Transition Type:

☐ Nursing Facility (NF)
Higher to lower Level of Care (LOC):
- ☐Acute inpatient (IP)
- ☐Residential Treatment Center (RTC)
- ☐Social detoxification program
- ☐Treatment Foster Care (TFC)
- ☐Other (specify)

☐ Turning 21 (complete sections 1, 5, and 6 only)
☐ Substance exposed infants: 60 days prior to graduation from Comprehensive Addiction and Recovery Act (CARA) program (complete sections 1, 2, 5, and 7 only)
☐ CISC 066/086 Members (sections 1, 2, 5, and 8 only)
☐ Other (specify)

This section will only be completed/populated into the TOC plan provided for Members discharging from a facility.

2. Coordination with Discharge (D/C) Planning Team **If no needs are identified for a requirement, enter "none" in Needs column**			
Summary of contact attempts (if d/c planning team was not reached, enter "None" in "Needs Identified by D/C Planning Team column)			
	Requirement	**Needs Identified by D/C Planning Team**	**Actions**
1.	Need for Home and Community Based Services	☐None ☐Yes (if yes, describe)	

2.	Follow-up appointments	☐None ☐Yes (if yes, describe)	
3.	Therapies and treatments	☐None ☐Yes (if yes, describe)	
4.	Medications	☐None ☐Yes (if yes, describe)	
5.	Durable Medical Equipment (DME)	☐None ☐Yes (if yes, describe)	

This section will not be completed for Members Turning 21 and will only populate into the TOC plan provided to the Member if it is completed.

3. Transition of Care (TOC) Assessment/Plan

If no needs are identified for a requirement, enter "none" in Needs column

Requirement		Needs	Actions
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	
2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Community Benefits	☐None ☐Yes (if yes, describe)	
4.	Continuation of Medicaid eligibility	☐None ☐Yes (if yes, describe)	
5.	PH/BH providers	☐None ☐Yes (if yes, describe)	
6.	Community resource providers	☐None ☐Yes (if yes, describe)	
7.	Housing	☐None ☐Yes (if yes, describe)	
8.	Financial	☐None ☐Yes (if yes, describe)	
9.	Interpersonal skills	☐None ☐Yes (if yes, describe)	
10.	Safety	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided to the Member if they require a 3-Day Post-Discharge In-Home Assessment (Members transitioning from inpatient hospital or NF stay who may be in need of Community Benefits).

4. 3-Day Post-Discharge In-Home Assessment

If no needs are identified for a requirement, enter "none" in Needs column

Requirement		Needs	Actions
1.	Safety in the home environment	☐None ☐Yes (if yes, describe)	
2.	Physical Health Needs	☐None ☐Yes (if yes, describe)	
3.	Behavioral Health Needs	☐None ☐Yes (if yes, describe)	

4.	Housing Needs	☐None ☐Yes (if yes, describe)	
5.	Continuation of Medicaid Eligibility	☐None ☐Yes (if yes, describe)	
6.	Financial Needs	☐None ☐Yes (if yes, describe)	
7.	CNA **if one is not in place**	☐None ☐Yes (if yes, describe)	
8.	Community Benefit needs and services in place	☐None ☐Yes (if yes, describe)	

5. Monthly Follow-Up (for 3 months)

The Transition of Care Plan shall remain in place for a minimum of 60 calendar days from the date of the decision to pursue transition or until the transition has occurred and a new CCP is in place. If the CCP is in place prior to the 3rd monthly follow-up, that assessment is not required to be conducted. If no needs are identified for a requirement, enter "none" in Additional Needs/Notes column. Additional rows may be added to accommodate further follow-up.

	Date	Additional Needs/Notes
1.		☐None ☐Yes (if yes, describe)
2.		☐None ☐Yes (if yes, describe)
3.		☐None ☐Yes (if yes, describe)

This section will only be completed/populated into the TOC plan provided for Members turning 21.

6. Transition for Members Turning 21

If no needs are identified for a requirement, enter "none" in Needs column

	Requirement	Needs	Actions
1.	Health condition management	☐None ☐Yes (if yes, describe)	
2.	Developmental and functional independence	☐None ☐Yes (if yes, describe)	
3.	Education	☐None ☐Yes (if yes, describe)	
4.	Social and emotional health	☐None ☐Yes (if yes, describe)	
5.	Continuity of BH services (if requested)	☐None ☐Yes (if yes, describe)	
6.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	
7.	Transportation	☐None ☐Yes (if yes, describe)	
8.	EPSDT services and provider needs	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided for CARA Members.

7. Transition for Members Graduating from CARA If no needs are identified for a requirement, enter "none" in Needs column			
Requirement		**Needs**	**Actions**
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	
2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Well care visits	☐None ☐Yes (if yes, describe)	
4.	Developmental and functional milestones	☐None ☐Yes (if yes, describe)	
5.	CYFD involvement	☐None ☐Yes (if yes, describe)	
6.	Current placement	☐None ☐Yes (if yes, describe)	
7.	PH/BH providers	☐None ☐Yes (if yes, describe)	
8.	Education for parent/guardian	☐None ☐Yes (if yes, describe)	
9.	DME/service needs	☐None ☐Yes (if yes, describe)	
10.	Community resources	☐None ☐Yes (if yes, describe)	
11.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided for CISC Members.

8. Transition for CISC 066/086 Members If no needs are identified for a requirement, enter "none" in Needs column			
Requirement		**Needs**	**Actions**
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	
2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Well care visits	☐None ☐Yes (if yes, describe)	
4.	Developmental and functional milestones	☐None ☐Yes (if yes, describe)	
5.	CYFD involvement	☐None ☐Yes (if yes, describe)	
6.	Current placement and permanency plan	☐None ☐Yes (if yes, describe)	
7.	PH/BH providers	☐None ☐Yes (if yes, describe)	

8.	Education for parent/guardian	☐None ☐Yes (if yes, describe)	
9.	DME/service needs	☐None ☐Yes (if yes, describe)	
10.	Community resources	☐None ☐Yes (if yes, describe)	
11.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	
12.	Transitioning to a new MCO (if applicable)	☐None ☐Yes (if yes, describe)	