Transition Rights in Managed Care Plans - Rights of New Enrollees to Continue Receiving Services

Know Your Rights: What You Need to Know About Medicaid Coverage for Transition-Related Care

States must have in effect a t**ransition of care policy** to ensure continued access to services during a transition from Fee for Service Medicaid (FFS) to a Managed Care plan or transition from one Managed care plan to another "when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization." This is required by federal regulations as amended in 2016. 42 C.F.R. Â§ 438.62, and is incorporated in the CMS Special Terms & Conditions of the waiver that authorizes the managed care program in NYS (Web) - (PDF) (Oct. 2021) (Article V(4)(g) at pp. 32-33).

- The transition policy must ensure that the "enrollee 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 [plan's] network." 42 C.F.R. Â§ 438.62 . The transition policy also must ensure that the enrollee is referred to in-network providers. The new plan and providers must also have access to the enrollee's previous medical records and plans of care.

- Before the federal regulation was enacted in 2016, NY Public Health Law required limited transition rights. Plans have long been required to provide access to a new enrollee's providers who are out of network, under limited conditions. See NY Public Health Law Â§ 4403, subd. 6(f). This was incorporated in a DOH transitional care policy which clarifies that continuity of care includes certified home health agency care, for new enrollees who are receiving an ongoing course of treatment upon enrollment.

Transition Policy Must be Publicly Available

- The 2016 federal regulations require, "State must make its transition of care policy publicly available and provide instructions to enrollees and potential enrollees on how to access continued services upon transition. At a minimum, the transition of care policy must be described in the quality strategy, under Â§ 438.340, and explained to individuals in the materials to enrollees and potential enrollees, in accordance with Â§ 438.10." 42 C.F.R. Â§ 438.62(b)(3).

- NYS has posted its Quality Strategy (updated March 2022). However, the transition rights (page 4 of the PDF) discuss solely the rights described above regarding the right to see out of network providers for 60 days, the rights of pregnant women, and rights if provider leaves network. It does not address consumer rights to continuity of services, not just providers, in transition from fee for service or from

one Managed care plan to another "when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization." 42 CFR 438.62. The State has issued policies limited to certain situations, such as when an MLTC plan closes - see MLTC Policy 17.02: *MLTC Plan Transition Process - MLTC Market Alteration.* However, these policies fall short of fully protecting enrollees. See more about MLTC transition rights, with harmful changes effective Nov. 2021, here.

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