Transition of Care

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1.0 Purpose

1.1 Continued Access to Care for members transitioning from a predecessor plan to Advanced Health. Advanced Health will ensure access without

delay for covered medical services, prescription drugs, care coordination and continuation of previously authorized service.

2.0 Scope

2.1 This rule applies to care of a Medicaid member who is enrolled in a CCO (the receiving CCO) immediately after disenrollment from a predecessor plan, which may be another CCO (including disenrollment resulting from termination of the predecessor CCOs contract) or Medicaid fee-for-service (FFS). This rule does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan.

3.0 Acronyms and Definitions

3.1 For purposes of this rule, the following additional definitions apply:
Continued Access to Care means, during a member's transition of care from the predecessor plan to the receiving CCO, providing access without delay to:

a) Medically necessary covered services;
b) Prior authorized care;
c) Prescription drugs; and
d) Care coordination, as defined in OAR 410-141-3860 and 410-141-3870.

3.1.2 Medically Fragile Children as defined by 411-300-0110 means children that have a health impairment that requires long-term, intensive, specialized services on a daily basis, who have been found eligible for MFC services by the Department of Human Services (DHS);

3.1.3 Prior Authorized Care means covered services that were authorized by the predecessor plan. This term does not, however, include health-related services approved by the predecessor plan;
3.1.4 Transition of Care means the period of time after the effective date of enrollment with the receiving CCO, during which the receiving CCO must provide continued access to care. The transition of care period lasts for:

a) Ninety days for members who are dually eligible for Medicaid and Medicare; or

b) For other members, the shorter of:

(i) Thirty days for physical and oral health and 60 days for behavioral health; or

(ii) Until the enrollee's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the members treatment plan.

4.0 Policies

4.1 Advanced Health has implemented and will maintain a transition of care policy that, at a minimum, meets the requirements defined in this rule and 42 CFR 438.62(b). A receiving CCO must provide continued access to care to, at minimum, the following members:

a) Medically Fragile Children;
b) With Special Health Care Needs
c) Those receiving Long Term Services and Supports, including members currently receiving either Medicaid funded Long Term Care or Long Term Services and Supports from DHS
d) Who are transitioning from Hospital or Skilled Nursing Facility care
e) Who are transitioning from institutional or in patient Behavioral Health care
f) Who are receiving Home and Community Based Services for Behavioral Health conditions
g) FBDE M Affiliated MA or DSN Plans in order to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination of member outcomes.
h) Breast and Cervical Cancer Treatment program members;
i) Members receiving CareAssist assistance due to HIV/AIDS;
j) Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and
k) Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

4.2 Receiving CCO obligations during the transition of care period:

4.2.1 The receiving CCO shall ensure that any member identified in section (3) has continued access to care and Non-Emergency Medical Transportation (NEMT);
4.2.2 The receiving CCO shall permit the member to continue receiving services from the members previous provider, regardless of whether the provider participates in the receiving CCOs network, until one of the following occurs:

a) The minimum or authorized prescribed course of treatment has been completed; or

b) The reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified provider.

4.2.3 Notwithstanding section (4)(b), the receiving CCO is responsible for continuing the entire course of treatment with the recipient's previous provider as described in the following service-specific transition of care period situations:

a) Prenatal and postpartum care;

b) Transplant services through the first-year post-transplant;

c) Radiation or chemotherapy services for the current course of treatment; or

d) Prescriptions with a defined minimum course of treatment that exceeds the transition of care period.

4.2.4 Where this section (4) allows the member to continue using the members previous provider, the receiving CCO shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less then Medicaid fee-for-service rates;
4.2.5 The receiving CCO is not responsible for paying for inpatient hospitalization or post hospital extended care for which a predecessor CCO was responsible under its contract.

5.0 Procedures

5.1 After the transition of care period ends, the receiving CCO remains responsible for care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.

5.2 A receiving CCO shall obtain written documentation as necessary for continued access to care from the following:
5.2.1 The Authority's clinical services for members transferring from FFS;
5.2.2 Other CCOs; and
5.2.3 Previous providers, with member consent when necessary.

5.3 During the transition of care period, a receiving CCO shall honor any written documentation of prior authorization of ongoing covered services:
5.3.1 CCOs shall not delay service authorization for the covered service if written documentation of prior authorization is not available in a timely manner;
5.3.2 In such instances, the CCO is required to approve claims for which it has received no written documentation during the transition of care time period, as if the covered services were prior authorized.

5.4 The predecessor plan shall comply with requests from the receiving CCO for complete historical utilization data within seven calendar days of the request from the receiving CCO.
5.4.1 Data shall be provided in a secure method of file transfer;
5.4.2 The minimum elements provided are:
a) Current prior authorizations and pre-existing orders;
b) Prior authorizations for any services rendered in the last 24 months;
c) Current behavioral health services provided;
d) List of all active prescriptions; and
e) Current ICD-10 diagnoses.

5.5 The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3835 and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet the requirements of 42 CFR 438.404 and OAR 410-141-3885.

6.0 Reference Sources

OAR 410-141-3860
OAR 410-141-3870
OAR 411-300-0110
OAR 410-141-3835
OAR 410-141-3885
42 CFR 438.62 (b)
42 FR 438.404

7.0 Responsibilities

Medical Management Dept- Ensure that all TOC authorizations are entered into the system.

Care Coordination Dept- Ensure that ICC services are available for the TOC members who would like to participate.

Claims Dept- management of all data files from the state TOC exchange and ensure that TOC claims are paid.

Member Services Dept- Identification of members who qualify for TOC. Make TOC policy and procedure document available via website.

8.0 Related Documents

9.0 Attachments

10.0 Approvals

Document Owner: Leah Lorincz
Name

Approved: *Leah Lorincz*
Signature

Title: Director of Member Services

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