Transition of Care Policy and Procedures

Company: Advanced Health	Approved by: Samyukta Vendrathi Title: Chief Operating Officer Current Revision Date: 12/29/2025 Current Review Date: 12/29/2025
Department: Medical Management	

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1. 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 services.

2. SCOPE

2.1. Advanced Health contracts with DOCS Management Services (DOCS) for most administrative and operational functions. Advanced Health, through a privileged provider agreement, delegates delivery of all physical health, behavioral health, and pharmacy services, including certain administrative functions, to Southwest

Oregon IPA, Inc. (SWOIPA) as part of operational and compliance management. In addition, SWOIPA further subdelegates administrative and operational tasks to ensure effective benefit administration and program operation under their privileged provider agreement to DOCS Management Services. These responsibilities include, but are not limited to, the development, review, approval, and ongoing maintenance of policies and procedures necessary to fulfill contractual and regulatory requirements. All contracted activities remain subject to oversight and accountability measures established by Advanced Health to ensure compliance with applicable laws, regulations, and organizational standards

2.2. This rule applies to care of Advanced Health Members 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 has a gap in coverage following disenrollment from the predecessor plan.

3. ACRONYMS AND DEFINITIONS

3.1. Unless otherwise defined, all uppercase words will be defined the same as in the CCO Contract.

3.2. Continued Access to Care refers to providing the Member with access to the following, without delay to the Member:

3.2.1. Medically necessary covered services;

3.2.2. Prescriptions; and

3.2.3. Prescription drug coverage.

3.2.4. Continues Access to Care will be provided in alignment with access the Member previously had including permitting the Member to retain their current provider, even if that provider is not in the CCO network.

3.3. Medically Fragile Children (MFC), as defined by OAR 411-300-0110, refers to 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)

3.4. Transition of Care Period refers to the period of time after the effective date of enrollment with the receiving CCO, during which the receiving CCO must provide continued access to services. The transition of care period lasts for:

3.4.1. Ninety (90) days for Members who are dually eligible for Medicaid and Medicare; or

3.4.2. For other Members, the shorter of:

3.4.2.1. Thirty (30) days for physical and oral health and sixty (60) days for behavioral health; or

3.4.2.2. Until the enrollee's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the Member's treatment plan; or the minimum or authorized prescribed course of treatment has been completed.

4. POLICIES

4.1. Advanced Health shall implement and will maintain a transition of care policy that, at a minimum, meets the requirements defined in OAR 410-141-3850 and 42 CFR 438.62(b). Advanced Health will provide continued access to care to, at a minimum, the following Members:

4.1.1. Medically Fragile Children;

4.1.2. Breast and Cervical Cancer Treatment program Members;

4.1.3. Members receiving CareAssist assistance due to HIV/AIDS;

4.1.4. Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and

4.1.5. 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.

4.1.5.1. The Chief Medical Officer will be responsible for determining if a Member transitioning from a different CCO meets this criteria.

4.2. Advanced Health has the following obligations during the transition of care period in accordance with OAR 410-141-3850(4):

4.2.1. Ensure that any Member identified in section 4.1 has continued access to care and Non-Emergency Medical Transportation (NEMT);

4.2.2. Permit the Member to continue receiving services from the Members previous provider, regardless of whether the provider participates in Advanced Health's network.

4.2.3. Member is referred to appropriate providers of services that are in the network at the duration of the Transition of Care period.

4.2.4. Continue the entire course of treatment with the recipient's previous provider as described in the following service-specific transition of care period situations:

4.2.4.1. Prenatal and postpartum care;

4.2.4.2. Transplant services through the first-year post-transplant;

4.2.4.3. Radiation or chemotherapy services for the current course of treatment; or

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

4.2.5. Where OAR 410-141-3850(4) allows the Member to continue using the Member's previous provider, reimburse non-participating providers consistent with OAR 410-120-1295 at no less than Medicaid fee-for-service rates;

4.2.6. During the transition of care period, Advanced Health is not responsible for paying for inpatient hospitalization or for which a predecessor CCO was responsible under its contract.

4.3. After the transition of care period ends, Advanced Health shall provide care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.

4.4. In the event that Advanced Health is the predecessor CCO, Advanced Health shall comply with requests from the receiving CCO for complete historical utilization data within seven calendar days of the request from the receiving CCO.

4.4.1. Data shall be provided in a secure method of file transfer;

4.4.2. The minimum elements provided are:

4.4.2.1. Current prior authorizations and pre-existing orders;

4.4.2.2. Prior authorizations for any services rendered in the last 24 months;

4.4.2.3. Current behavioral health services provided;

4.4.2.4. List of all active prescriptions; and

4.4.2.5. Current ICD-10 diagnoses.

4.5. In the event that Advanced Health is the receiving CCO, and historical utilization data and clinical records is not available in a timely manner, Advanced Health shall not delay the provision of services.

4.5.1. In such instances, Advanced Health shall do the following:

4.5.1.1. approve claims for which it has received no historical utilization data and clinical records during the transition of care time period, as if the covered services were prior authorized.

4.5.1.2. have a process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR 170.213. Such information must be incorporated into records about the current member. With the approval and at the direction of a current or former Member or the Members' personal representative, Advanced Health shall:

4.5.1.2.1. Receive all such data for a current member from any other payer that has provided coverage to the enrollee within the preceding 5 years;

4.5.1.2.2. At any time the member is currently enrolled in CCO and up to 5 years after disenrollment, send all such data to any other payer that currently covers the enrollee or a payer the enrollee or the enrollee's personal representative specifically requests receive the data; and

4.5.1.2.3. Send data received from another payer, listed above, in the electronic form and format it was received.

4.6. Advanced Health 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.

4.7. Advanced Health shall not discriminate against individuals eligible to enroll on any basis or use any policy or practice that has the effect of discriminating against individuals eligible to enroll on any basis, including: age, disability; national origin, primary language, and proficiency of the English Language; race, religion, color; sex, sex characteristics, sexual orientation, gender identity, or sex stereotypes; Pregnant or related conditions; or health status or need for services

5. PROCEDURES

5.1. Advanced Health shall obtain written documentation as necessary for continued access to care from the following:

5.1.1. The Authority's clinical services for Members transferring from FFS;

5.1.2. Other CCOs; and

5.1.3. Previous providers, with Member consent when necessary.

5.2. Advanced Health shall employ automated processes whenever possible to identify Members that are eligible for transition of care services as defined in section 4.1.

5.2.1. All manual requests for transition of care of a Member shall be directed to the Customer Service team.

5.2.1.1. Upon receipt, the Customer Service team will forward all relevant information to the Utilization Review (UR) teams for further processing.

5.2.1.2. The UR teams will review and determine member eligibility.

5.2.1.3. The UR teams will enter and update all relevant requests in the Quantum Choice (QC) system.

5.2.1.3.1. The UR teams will note TOC in QC for reporting and monitoring purposes.

5.2.2. Designated staff will review the Transition of Care (TOC) dashboard on a recurring basis to identify new Members who have transitioned and meet the established TOC eligibility criteria. For all eligible members, authorization and other relevant information will be collected and entered into QC. Authorizations shall include complete and accurate details, including: (1) the authorization date range, (2) service quantities, and (3) provider and service type information. Once entered, the authorization will be pended to the designated TOC queue for processing and review by the appropriate individual.

5.3. If Advanced Health identifies that a Member may require transition of care services outside of automated processes, Advanced Health will coordinate with the proceeding CCO or OHA as necessary.

5.4. During the transition of care period, Advanced Health shall honor any written documentation of prior authorization of ongoing covered services:

5.4.1. CCOs shall not delay service authorization for the covered service if written documentation of prior authorization is not available in a timely manner;

5.4.2. 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.

5.5. In the event that Advanced Health is the predecessor CCO, Advanced Health will rely on automated processes to respond within the mandated timeframes whenever possible in response to electronic requests.

6. REFERENCE SOURCES

6.1. 42 CFR 438.62 Continued Services to Enrollees
6.2. OAR 410-141-3860 Care Coordination: Administration, Systems and Infrastructure
6.3. OAR 410-141-3870 Care Coordination: Service Coordination
6.4. OAR 410-141-3850 Health System Division: Medical Assistance Programs-Transition of Care
6.5. OAR 411-300-0110 Division 300
CHILDREN'S INTENSIVE IN-HOME SERVICES (CIIS) Acronyms and Definitions
6.6. OAR 410-141-3835 MCE Service Authorization
6.7. OAR 410-141-3885 Grievances & Appeals: Notice of Action/Adverse Benefit Determination
6.8. CFR 438.62 (b) Continued Services to Enrollees
6.9. CFR 438.404 Timely and adequate notice of adverse benefit determination

7. RESPONSIBILITIES

(Compliance, Monitoring, Review)

7.1. Director of Medical Services- ensures all TOC authorizations are entered into the system.
7.2. Care Coordination Dept- Ensure that care coordination services are available for the TOC Members who would like to participate.
7.3. Claims Dept ensures that physical health and mental health claims, including those pertaining to TOC, are processed in accordance with state and federal regulations.
7.4. Member Services Dept- Identification of Members who qualify for TOC. Make TOC policy and procedure document available via website.
7.5. HIMS Department is responsible for management and processing of TOC files from the state as well as electronic requests to predecessor CCO's and electronic responses to receiving CCOs.
7.6. Analytics Department will maintain a dashboard or reports as needed to inform utilization management team of new TOC eligible Members and related authorization history from the predecessor CCO.

8. RELATED DOCUMENTS

8.1. Care Coordination Policy and Procedure
8.2. Covered and noncovered Services Policy and Procedure
8.3. Utilization Review Policy and Procedure

9. ATTACHMENTS

9.1. HIMS TOC Workflow

10. HEALTH EQUITY IMPACT ASSESSMENT TOOL

(If question does not apply, answer "Does Not Apply")

10.1. Does the policy advance equity and what are the intended outcomes? How? If not, does it have the potential to ignore or worsen existing disparities or produce other unintended consequences, should this policy be enacted? If so, what mitigation should be planned?	The policy advances equity by ensuring continuity of care for vulnerable Medicaid populations, focusing on groups historically underserved. It reduces care disruptions through measures like honoring prior authorizations and reimbursing non-network providers. However, risks include short transition periods, provider network gaps, data transfer delays, and communication barriers, which could worsen

	disparities. Mitigation strategies include extending transition periods, improving provider networks, and enhancing data-sharing systems.
10.2. Was there equitable involvement in the drafting or revision process? How have you included those impacted in the process? Who else should be involved? Who is the focus and who may be being left out?	Equitable involvement was present noted by the reference sources (OARs) which include feedback from Members on a state level.
10.3. What are the potential equity-related disparate impacts of this policy, practice, or decision? How might this policy have a disproportionate impact, negatively or positively on those historically underrepresented or excluded? How does this policy, practice or decision perpetuate or help to dismantle historical or other barriers to equity?	This policy supports equitable care by ensuring vulnerable Medicaid Members have uninterrupted access to services during transitions between CCOs. It prioritizes populations historically excluded from quality care, including medically fragile children, individuals with chronic conditions, and those needing behavioral health or long-term care. However, challenges like limited provider networks, short transition periods, and data-sharing inefficiencies could disproportionately impact underrepresented groups, especially in rural areas. Communication barriers, such as language or health literacy issues, may further limit access for diverse populations. However, Advanced Health offers language services in a variety of languages and a Care Coordinator employee can be assigned to assist a Member navigate through medical health jargon. The policy helps dismantle inequities by honoring prior authorizations, reimbursing non-network providers, and focusing on high-need groups. Enhancements like extended transition periods, better provider networks, and improved data sharing could strengthen its equity impact.
10.4. What accountability, infrastructure and resources are required to implement the policy with the goal of advancing health equity?	To implement this policy with a focus on advancing health equity, clear accountability is essential, including dedicated oversight roles, performance metrics, and transparent reporting to track disparities and outcomes. Adequate provider networks with culturally and linguistically competent professionals are necessary, especially in rural areas. Resources should include funding for care coordinators, training on cultural competency and equity, and support services like interpretation and transportation. Accessible, multilingual communication channels will help Members navigate the transition process effectively. Investments in technology and analytics can help identify and address service gaps proactively.

	Together, these measures ensure equitable, uninterrupted care for all Members.
10.5. What is the plan to evaluate and monitor the policy, practice, or decision to ensure equity in the short- and long-term?	To evaluate and monitor the policy for equity, initial data should be collected on transition outcomes, focusing on service continuity, provider availability, and Member satisfaction, particularly for vulnerable populations. Short-term monitoring should involve Member feedback through surveys and focus groups, alongside regular reporting on issues like data sharing and non-network provider reimbursements. Long-term evaluation should include annual reviews of the policy's impact on health equity. Ongoing data analysis will assess health outcomes and service utilization, ensuring continuous policy adjustments.

11. APPROVALS	
11.1 – Document Owner	Name and Title: Jaime Simmons, Director of Medical Services Department: Medical Management
11.2 – Approving Manager	Name and Title: Samyukta Vendrathi, Chief Operating Officer Department: Administration Signature: Samyukta Vendrathi _____
11.3 – Collaborators	Name(s) and Title(s): Ross Acker -Director of Care Coordination Jacqueline Bohannon-Manager of Claims Chris Wilson- Director of HIMS
11.4 – Approvals	**Policy Review Committee** Date Approved: 12/30/2025 **OHA Approval (if needed)** Date Approved:
11.5 – Original Effective Date **11.6 – Review Period** **11.7 – Review Date(s)** **11.8 – Revision Date(s)**	**Date: 12/30/2020** **How often PnP is reviewed: Annual** **Date: 12/29/2025** **Date: 12/29/2025**
11.9 – Add to Advanced Health Website	☐

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