Transition of Care - Medicaid

State(s):	LOB(s):
☐ *Idaho* ☐ *Montana* ☒ *Oregon* ☐ *Washington* ☐ *Other:*	☐ *Commercial* ☐ *Medicare* ☒ *Medicaid*

Government Medicaid Policy

Transition of care (TOC) is a process that ensures continuity of care for new members including those that transfer between a Coordinated Care Organization (CCO) or the traditional Fee-for-Service (FFS) delivery system and PacificSource Community Solutions (PCS). The transition of care process is designed to improve access to necessary medical services, ensure coordination of care, and improve quality of care, as defined in Oregon Administrative rule 410-141-3860 and 410-141-3870.

Procedure

Incoming Members

PCS will cover transition of care immediately after disenrollment of the member from another CCO or from FFS. Both instances shall be considered a predecessor plan. PCS, the receiving CCO, will provide medically necessary covered services and care coordination without delay during each member's transition of care consistent with applicable federal and state law, pursuant to OAR 410-141-3850 and Exhibit X of the CCO contract.

Care coordination forms will be included in new member materials to allow members to self-identify possible transition of care needs. Transition of care will be provided to all members specified below who are transferring care from a different CCO or FFS. In addition, members who have transitioned to PCS with current medical needs, including but not limited to currently pre-authorized services and members receiving Behavioral Health services, are sent a letter and have telephonic outreach by PCS Customer Service Representatives detailing care management services that are available to the member.

PCS will provide, at a minimum, support for transition of care to member in the Priority Populations:

- Medically fragile children;
- Breast and Cervical Cancer Treatment program members;
- Members receiving CareAssist assistance due to HIV/AIDS;
- Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation or chemotherapy services;
- Members discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health programs in the last 12 calendar months
- Members participating in Oregon's CMS approved 1915(k) and 1915 (c) programs; and
- Any member who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

PCS shall ensure that any member identified above has continued access to care and Non-Emergency Medical Transportation (NEMT).

Pursuant to OAR 410-141-3850, the transition of care period begins after the effective date of enrollment in PCS and continues until:

- Thirty (30) days for physical and oral health;
- Sixty (60) days for behavioral health; or
- Until the new member's Primary Care Provider (PCP), oral or behavioral health provider (as applicable to medical, dental or behavioral health care services) reviews the member's treatment plan, whichever comes first;
- Ninety (90) days for members who are dually eligible for Medicaid and Medicare.

PCS will allow any member identified for transition of care to retain their previous provider for the transition period as noted above, including out-of-network providers, except:

- After the minimum or authorized prescribed course of treatment has been complete; or
- The reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans will be reviewed by a qualified provider.

PCS will cover the entire course of treatment with the member's previous provider for:

- Prenatal and postpartum care;
- Transplant services through the first-year post-transplant;
- Radiation or chemotherapy services for the current course of treatment; or
- Prescriptions with a defined minimum course of treatment that exceeds the continuity of care period.

PCS will reimburse non-participating providers at no less the Medicaid fee-for-service rates. PCS is responsible for such services, including those provided outside the state when such services cannot be provided within the timely access to care standards as required under OAR 410-141-3515.

PCS is not responsible for paying for inpatient hospitalization or post hospital extended care for which a predecessor CCO or Subcontractor was responsible under its contract.

PCS shall obtain written documentation as necessary for continued access to care from the following:

- The Division's clinical services for members transferring from FFS;
- Other CCOs; and
- Previous care providers, with member consent when necessary.

After the Transition of Care period ends, the receiving CCO is responsible for care coordination and discharge planning activities. 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 services were prior authorized.

PCS will establish resources for secure transmission of data for members transitioning into PCS within the timelines prescribed by the OHA (complete historical utilization data within 7 calendar days of the member's effective date). Data shall be provided in a HIPAA compliant format to facilitate transitions of care, and the minimum elements provided are:

- Current prior authorizations and pre-existing orders;
- Prior authorizations for any services rendered in the last 24 months;
- Current behavioral health services provided;
- List of all active prescriptions;
- Current ICD-10 diagnosis.

Information will be requested from the outgoing CCO or FFS as needed. PCS may also contact members directly, when necessary.

For identified TOC members, PCS will honor any written documentation of prior authorization of ongoing covered services from the predecessor plan during the transition period as noted above. PCS will not delay authorization of ongoing services if prior authorization from the predecessor plan is not available in a timely manner. PCS will approve claims for which it has not received written documentation during the transition period, as if services were authorized, assuming those services are covered benefits under the plan.

If PCS, does not authorize or reduces services preauthorized by predecessor plan, the member will receive a 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.

Continuity of Care

PCS may make continuity of care exception allowances outside of the transition of care time frame in the event the decision would be in the member's best clinical interest.

Outgoing Members

For members who are transitioning into a new CCO from PCS, the following information will be provided within 7 days of the request. Data shall be provided in a HIPAA compliant, secure format to facilitate transitions of care, and will include information on physical, dental, behavioral health and transportation services. The minimum elements provided are:

- Current prior authorizations and pre-existing orders;
- Prior authorizations for any services rendered in the last 24 months;
- Current behavioral health services provided;
- List of all active prescriptions;
- Current ICD-10 diagnosis.

PCS will work with all CCO's to establish working relationships and written agreements to facilitate transfer of care; we will also identify contacts for sending and receiving member data to ensure that appropriate information is provided to the new CCO to adequately coordinate the member's care. For those receiving CCOs that request additional member information, either verbally or in writing, the PCS Care Management team will connect with the receiving CCO, as well as with the member and the member's providers, if needed. In addition, reporting will be developed to identify members who are terming from PCS CCO and have been identified as needing care coordination. For members with known complex care needs, including those groups who are prioritized by the OHA, or who are actively being case managed by the PCS care management team, the care management team will similarly connect with the receiving CCO, as well as with the member and the member's providers, if needed. The goal of this connection is to ensure a seamless transition of care for the member.

Appendix

Policy Number:

Effective: 8/1/2019 **Next review:** 12/1/2021

Policy type: Government

Author(s): Shana Hodgson; Monte Hodge; Polly Watt-Geier

Depts.: Health Services

Applicable regulation(s): Oregon Administrative Rulebook Chapter 410, Division 141, Section 3850

Government OPs: 5/2021

Modification History

Date	Modified By	Reviewed By	Modifications
4/30/21	S. Hodgson M. Hodge P. Watt-Geier	Alison Little, MD	Replaced PSCS with PCS. Added continuity of care section. Updated policy to reflect most current OARs. Updated sentence structure for policy flow.
12/14/2020	S. Hodgson	Justin Montoya, MD Alison Little, MD	Deleted “While members can transfer either during the Open Enrollment Period or at another time, this process only addresses transfers that occur outside the Open Enrollment period”. Approved the policy with the above edit.
11/04/2020	S. Hodgson	Shana Hodgson	Based on HSAG MHP audit: updated policy to reflect TOC applies to any new PS CCO member not just those transitioning from another CCO or FFS.
2/18/2020	S. Hodgson L. LaFerriere	Alison Little, MD Justin Montoya, MD	OARs references updated to align with OHA updates to Oregon Health Plan (MCE and CCO) Administrative Rulebook Chapter 410, Division 141 Effective January 2, 2020
01/23/2020	Shana Hodgson	Shana Hodgson	OARs references updated to align with OHA updates to Oregon Health Plan (MCE and CCO) Administrative Rulebook Chapter 410, Division 141 Effective January 2, 2020
11/11/2019	Shana Hodgson Martin Stukel Jane Hannabach	Alison Little, MD Justin Montoya, MD	Updated to reflect OARs: 410-141-3850: data sharing timeline; notice of action OAR; deleted current provider under minimum elements; inpatient hospitalization or post hospital extended care.
7/24/2019		CQUM	Approved as written
6/24/2019	S. Hodgson Allison Little J. Hannabach L. Hopper J. Sayers M. Stukel R. Hanson	Justin Montoya, MD Alison Little, MD	Approved new policy as written
2/25/2019	Shana Hodgson	Shana Hodgson	Added clarity
01/31/2019	Cindy Seger		New policy