OAR 410-141-3850

Transition of Care

(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 CCO's 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.

(2) For purposes of this rule, the following additional definitions apply:
   (a) "Continued Access to Services" means making available to the member services, prescriptions, and prescription drug coverage consistent with the access they previously had including permitting the member to retain their current provider, even if that provider is not in the CCO network;
   (b) "Medically Fragile Children (MFC)" as defined by OAR 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);
   (c) "Transition of Care Period" 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 services. The transition of care period lasts for:
      (A) Ninety (90) days for members who are dually eligible for Medicaid and Medicare; or
      (B) For other members, the shorter of:
         (i) Thirty (30) days for physical and oral health and sixty (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 member's treatment plan; or the minimum or authorized prescribed course of treatment has been completed.

(3) CCOs shall implement and 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 services to, at minimum, the following members:
   (a) Medically Fragile Children (MFC);
   (b) Breast and Cervical Cancer Treatment program members;
   (c) Members receiving CareAssist assistance due to HIV/AIDS;
   (d) Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services (including pre-transplant and post-transplant services), radiation, or chemotherapy services; and
   (e) 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) During the Transition of Care Period the receiving CCO shall ensure that any member identified in section (3) of this rule:
   (a) Is provided with Continued Access to Services and has support necessary to access those services such as Non-Emergency Medical Transportation (NEMT);

(b) Is permitted to continue receiving services from the member's previous provider, regardless of whether the provider participates in the receiving CCO's network;
(c) Is referred to appropriate providers of services that are in the network at the duration of the Transition of Care period;
(d) Notwithstanding section (4)(b) of this rule, 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; or~~.~~
(E) HRSN Services through the authorized timeframe of service provision for each such service as set forth in a Member's PCSP, as described in OAR 410-120-XXXX.
(e) Where section (4) of this rule allows the member to continue using the member's previous provider, the receiving CCO shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less than Medicaid fee-for-service rates;
(f) The receiving CCO is not financially responsible for a continuous inpatient hospitalization for which a predecessor CCO was responsible under its contract, in accordance with OARs 410-141-3500, 410-141-3710, and 410-141-3805.

(5) 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.

(6) The Predecessor Plan shall fully and timely comply with request for historical utilization data and clinical records within seven calendar days of the request from the receiving CCO.
(a) CCOs shall not delay the provision of services if historical utilization data and clinical records is not available in a timely manner;
(b) In such instances, the CCO is required to 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. CCOs shall 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 the CCO's records about the current member. With the approval and at the direction of a current or former enrollee or the enrollee's personal representative, the CCO must:
(A) Receive all such data for a current member from any other payer that has provided coverage to the enrollee within the preceding 5 years;
(B) 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
(C) Send data received from another payer under this paragraph in the electronic form and format it was received.

(7) The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3835, and for HRSN Services all service authorization protocols outlined in OAR 410-120-XXXX, 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, and to the extent applicable, OAR 410-120-XXXX.