CORPORATE POLICY & PROCEDURE

	Policy Name: CE28 - Transition of Care
Department: Health Plan Operations	Policy Number: CE28
Version: 1	Creation Date: 12/03/2019
Revised Date:	
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek	☐ Umpqua Health Management ☐ Umpqua Health Network
Approved By: Michael A. von Arx (Chief Administrative Officer)	Date: 12/04/2019

POLICY STATEMENT

Umpqua Health Alliance (UHA) is committed to implementing and maintaining a transition of care policy that, at a minimum, meets the requirements defined in Oregon Administrative Rule (OAR) 410-141-3850 and 42 Code of Federal Regulation (CFR) § 438.62(b) to ensure its members receive continuity of care during plan transitions from Coordinated Care Organization (CCO) to CCO or Fee-For-Service (FFS) to CCO.

PURPOSE

To ensure UHA and other Oregon Health Plan (OHP) members have access to services consistent with the access they previously had for a period of time, and are permitted to retain their current provider for a period of time if that provider is not in the CCO network.

RESPONSIBILITY

Clinical Engagement, Clinical Pharmacy Services, Customer Care

DEFINITIONS

Continued Access to Care: During a member's transition of care from the predecessor plan to the receiving CCO, providing access without delay to: (1) Medically necessary covered services; (2) Prior authorized care; (3) Prescription drugs; and (4) Care coordination, as defined in OAR 410-141-3860 and 410-141-3870.

Medically Fragile Children (MFC): 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) per OAR 411.350-0020.

Predecessor plan: The plan that the member is transferring from which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's Contract) or Medicaid FFS.

Prior Authorized Care: Covered services that were authorized by the predecessor plan. This term does not, however, include health-related services approved by the predecessor plan.

Receiving CCO: The CCO that the member is transferring to for healthcare services.

Transition of Care (TOC): 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: (1) Ninety days for members who are dually eligible for Medicaid and Medicare; or (2) For other members, the shorter of: (i) 30 days for physical and oral health and 60 days for behavioral health; or (ii) Until the member's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan.

PROCEDURES

Identifying TOC Eligible Populations

1. TOC applies to Medicaid members who are enrolled in a CCO (the receiving CCO) immediately after disenrollment from a predecessor plan (a CCO or FFS). TOC does not apply to members who are ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan.
2. TOC, at minimum, is provided for the following members:
    a. Medically fragile children;
    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, 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.
3. Identifying members who qualify for TOC is the responsibility of the receiving CCO based on data provided by FFS and/or the predecessor plan.
4. The Oregon Health Authority (OHA or Authority) has provided CCOs with a "TOC Eligible Populations Matrix" which can assist CCOs in identifying some members who qualify for transition.

Data Sharing:

1. TOC extract files generated from Medicaid Management Information Systems (MMIS) and delivered to the electronic data interchange (EDI) Secure File Transfer Protocol (SFTP) mailboxes.
2. Data will be shared between plans using a SharePoint Document Portal site.
3. OHA data transmissions: To facilitate the execution of transition of care activities OHA will transmit the following ranges and types of information to the receiving CCO:
    a. 12 months of claims data including FFS and CCO encounter claims. This time period aligns with responses provided by CCOs in a November 2018 survey.
    b. 24 months of FFS prior authorizations / plan of care (a subsystem with some resemblance to prior authorization). This time period aligns with the utilization history requirements stated in OAR.
4. CCO data transmissions: CCOs responding to a request for information for a member will transmit the following ranges and types of information to the receiving CCO:

a. 24 months of CCO originated prior authorization information. This time period aligns with the utilization history requirements stated in OAR.
b. Existing care plans: Current, complete care plans should be provided to the receiving CCO by the predecessor plan.

When UHA is the Receiving CCO

1. UHA is responsible for identifying members that qualify for transition, as discussed above.
2. UHA shall ensure that any member identified has continued access to care and Non-Emergency Medical Transportation (NEMT).
3. UHA shall permit the member to continue receiving services from the member's previous provider, regardless of whether the provider participates in the receiving CCO's 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. UHA 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.
5. UHA shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less then Medicaid FFS rates;
6. UHA is not responsible for paying for health related services, inpatient hospitalization or post hospital extended care for which a predecessor CCO was responsible for under its contract.
7. After the transition of care period ends, UHA remains responsible for care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.
8. UHA shall obtain written documentation as necessary for continued access to care from the following:
    a. The Authority's clinical services for members transferring from FFS;
    b. Other CCOs; and
    c. Previous providers, with member consent when necessary.
9. During the transition of care period, UHA shall honor any written documentation of prior authorization of ongoing covered services:

   a. UHA shall not delay service authorization for the covered service if written documentation of prior authorization is not available in a timely manner;
   b. In such instances, UHA will 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.

10. The TOC period is the greater of the timelines listed below after the effective date of enrollment with UHA.
    a. 30 days for physical and oral health and 60 days for behavioral health or until the member's new PCP (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan, whichever comes first;
    b. 90 days for members who are dually eligible for Medicaid and Medicare.

<u>When UHA is the Predecessor CCO</u>

1. UHA shall comply with requests from the receiving CCO for complete historical utilization data within seven (7) calendar days of the request from the receiving CCO.
2. Data shall be provided in a secure method of file transfer or as discussed in the data sharing section.
3. 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;
   e. Current ICD-10 diagnoses; and
   f. Existing care plans.
4. UHA 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.

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Member Education of TOC Policy

1. UHA will explain its TOC policy with its members upon enrollment during primary care physician assignment calls, as well as in the Member Handbook and provide instruction to members and potential members on how to access continued services upon transition.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Health Plan Operations	N/A	N/A	N/A	N/A