CORPORATE POLICY & PROCEDURE

	Policy Name: CE28 - Transition of Care
Department: Health Plan Operations	Policy Number: CE28
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Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek	☐ Umpqua Health Management ☐ Umpqua Health Network
Approved By: Quality Improvement Committee	Date: 11/18/2025

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. This includes physical health, behavioral health, dental, and long-term services and supports (LTSS), as required by OAR 410-141-3850 and the OHA CCO Contract.

RESPONSIBILITY

Utilization Review, Pharmacy Services, Care Coordination, Customer Care and Claims

DEFINITIONS

Continued Access to Services: Making available to the member services 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. This includes DME and medical supplies, LTSS services, behavioral health services (including crisis services), oral health services, and ongoing prescriptions.

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 411-300-0110.

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.

Serious Detriment: A condition in which failure to continue services (including medications and DME) creates a risk of hospitalization, institutionalization, significant decline in functioning, significant pain, or worsening of a chronic or acute condition.

Transition of Care (TOC) Period: 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: (1) Ninety (90) days for members who are dually eligible for Medicaid and Medicare; or (2) 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 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; or the minimum or authorized prescribed course of treatment has been completed.

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, which may be another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (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. Continued access to services is provided, at minimum, for 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, radiation, or chemotherapy services
    e. Members receiving LTSS or home- and community-based services whose services cannot be safely interrupted
    f. Members actively engaged in behavioral health treatment, including SUD services; and
    g. 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. CCO data transmissions: UHA 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 UHA'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, UHA shall:
    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 section in the electronic form and format it was received.

4. UHA shall also:

    a. Make good-faith efforts to obtain missing TOC data when a predecessor plan does not transmit it.

b. Incorporate received data into the member's care plan, health record, and coordination workflow upon receipt.

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 services and support necessary to access those services, such as Non-Emergency Medical Transportation (NEMT). This includes continued access to DME, medical supplies, home health, LTSS and BH crisis services.
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.
4. UHA shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less then Medicaid FFS rates.

5. UHA shall refer members to appropriate providers of services that are in-network at the end of the TOC period.
6. 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.
    e. DME or prescription supplies requiring a minimum treatment duration that exceeds the TOC period.
7. UHA 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.
8. 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.
9. UHA shall obtain written documentation as necessary for continued access to services 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.
10. 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 historical utilization data and clinical records are not available in a timely manner;
    b. In such instances, UHA will approve claims for which it has received no historical utilization data and clinical records during the TOC period, as if the covered services were prior authorized.

When UHA is the Predecessor CCO

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;

c. Current behavioral health services provided;
d. List of all active prescriptions;
e. Current ICD-10 diagnoses; and
f. Existing care plans.
g. Current risk scores and risk stratification tier
h. Care team contact information
i. Member care coordination notes and TOC-related 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.

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.
2. TOC information will be provided in a culturally and linguistically appropriate manner, consistent with OAR 410-141-3810 and federal Limited English Proficiency requirements.
3. UHA will post TOC rights, including hoe to access continues services, on its public website.
4. UHA will inform members of their grievance and appeal rights when TOC services are denied, reduced or terminated.

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