Transition of Care - Medicaid

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

Medicaid Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Guideline and the Member's policy, the Member's policy language shall control. Guidelines do not constitute medical advice nor guarantee coverage.

Background

Transition of care (TOC) is a process that ensures continuity of care for new members including those that transition between a Coordinated Care Organization (CCO) or the traditional Fee-for-Service (FFS) delivery system and PacificSource Community Solutions (PCS). The TOC process is designed to improve access to necessary medical services, ensure coordination of care, and improve quality of care, as defined by the Oregon Health Authority (OHA) in Oregon Administrative Rules and 42 CFR §438.62(b).

Procedure

I. Incoming Members

PCS will cover TOC 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 TOC consistent with applicable federal and state law.

Care coordination forms will be included in new member materials to allow members to self-identify possible TOC needs. TOC 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 members with current prior authorization of services or for members

who are receiving behavioral health services. These members 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 TOC to members in the following Priority Populations:

- Medically fragile children (MFC)
- Breast and Cervical Cancer Treatment program members
- Members receiving CareAssist due to a diagnosis of HIV/AIDS
- Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services
- 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 will ensure that any member identified above has continued access to care and Non-Emergency Medical Transportation (NEMT).

TOC period begins after the effective date of enrollment in PCS and continues 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.
- For other members, the shorter of:
    - Thirty (30) days for physical and oral health
    - Sixty (60) days for behavioral health
    - 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 authorized prescribed course of treatment has been completed

PCS will allow any member identified for TOC to continue receiving services from their previous provider, including out-of-network providers, until one of the following occurs:

- After the minimum or authorized prescribed course of treatment has been complete
- 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 in the following service-specific transition of care period situations:

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

PCS will reimburse out-of-network providers consistent with OAR 410-120-1295 at no less than Medicaid Fee-For-Service (FFS) 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 regulatory standards.

PCS is not responsible for paying for inpatient hospitalization or post-hospital extended care for which a previous CCO or Subcontractor was responsible to provide under its contract, in accordance with OARs 410-141-3500, 410-141-3710, and 410-141-3805.

Note: This does not apply to all hospitalizations, and only applies to those inpatient hospitalizations defined as a "continuous inpatient stay" per OAR 410-141-3500(23).

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
- Previous care providers, with member consent when necessary

After the TOC period ends, the receiving CCO is responsible for care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.

PCS is required to approve claims for which it has received no written documentation during the TOC 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 seven (7) calendar days of the member's effective date). Data shall be provided in a HIPAA compliant format to facilitate transitions of care, and must include the following minimum elements:

- Current prior authorizations and pre-existing orders
- Prior authorizations for any services rendered in the last 5 years
- Current behavioral health services provided
- List of all active prescriptions
- Current ICD-10 diagnoses

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 previous plan during the transition period as noted above. PCS will not delay authorization of ongoing services if prior authorization from the previous 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 which were prior authorized by the previous plan, the member will receive a written notice. The written notice will include any denial decision of a service authorization request or the amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice shall meet regulatory requirements.

II. Continuity of Care

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

III. Outgoing Members

For members who are transitioning into a new CCO from PCS, the following information will be provided within seven (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 following minimum elements will be provided:

- Current prior authorizations and pre-existing orders
- Prior authorizations for any services rendered in the last 5 years
- Current behavioral health services provided
- List of all active prescriptions
- Current ICD-10 diagnosis

PCS will work with all other CCOs to establish working relationships and written agreements to facilitate transfer of care. PCS 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 receiving care management services 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 TOC for the member.

Definitions

Continued Access to Services – making available to the member services, prescriptions, and prescription drug coverage consistent with the access they previously had.

Continuous Inpatient Stay - An uninterrupted period of time a member spends as inpatient, regardless of whether there have been changes in assigned specialty or facility during the stay. This includes discharge transfer to another inpatient facility, in or out of state, such as another acute care hospital, acute care psychiatric hospital, skilled nursing facility, psychiatric residential treatment facility (PRTF) or other residential facility for inpatient care and services.

Related Policies

Medicaid Care Management (Care Coordination)

Medicaid Utilization Management/Service Authorization Handbook PacificSource Community Solutions

References

42 CFR Subpart B – State Responsibilities §438.62.

Oregon Administrative Rules (OARs): 410-141-3500(23), 410-141-3515, 410-141-3850, 410-141-3860, 410-141-3870, and OAR 410-141-3885

Oregon Health Plan, Health Plan Services Contract. Coordinated Care Organization Contract with PacificSource Community Solutions, Inc.

Appendix

Policy Number:

Effective: 8/1/2019 **Next review:** 1/1/2026

Policy type: Government

Author(s):

Depts.: Health Services

Applicable regulation(s): 42 CFR 438.62(b), OARs 410-141-3500(23), 410-141-3850, 410-141-3515, 410-141-3860, 410-141-3870 and 410-141-3885.

Government OPs: 12/2024