**POLICY AND PROCEDURE**

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| **DEPARTMENT:**<br>**Case Management** | **DOCUMENT NAME:**<br>**Transitions of Care between Coordinated Care Organizations** |
| **PAGE: 1 of 4** | **REPLACES DOCUMENT: N/A** |
| **APPROVED DATE: 7/18/2019** | **RETIRED: N/A** |
| **EFFECTIVE DATE: 12/1/2019** | **REVIEWED/REVISED: 11/2019** |
| **PRODUCT TYPE: Medicaid, OHP** | **REFERENCE NUMBER: OR.CM.06** |

SCOPE: Transitions of care for members transitioning from one Coordinated Care Organization (CCO) to another CCO.

PURPOSE: To ensure the transition of care of a Medicaid member who is enrolled in Trillium Community Health Plan (the CCO) to the receiving CCO immediately after the member is dis-enrolled from the CCO. This transition includes disenrollment from another CCO resulting from termination of the predecessor CCO's contract, choice or from Medicaid fee-for-service (FFS) to allow for continued access to care.

For New Members Enrolled with a different CCO under a under a CCO contract on December 1, 2019, Trillium shall cooperate with OHA and such CCO to ensure such New Members are transitioned over to Trillium's plan in accordance with its Plan for Member Transition and with the applicable requirements set forth in Ex. D, Sec.10, relating to the continuation of services, obtaining medical records, Care Coordination, and other requirements as deemed necessary to ensure an orderly transition of the New Member's health care without a disruption to such New Member's health care needs.

POLICY:

1. Transitioning members:
   - 1.1. Trillium shall permit, as set forth below in this Sub.Para. (c), New Members to continue receiving physical and Behavioral Health care services from their existing Primary Care and Behavioral Health Care Providers regardless of whether such Providers are located within or outside Trillium's Service Area and regardless of whether such Providers are Participating or Non-Participating Providers:
     - 1.1.1. Primary Care Providers for up to ninety (90) days; and
     - 1.1.2. Behavioral Health Care Providers for up to one hundred and eighty (180) days.
   - 1.2. Coordination with member and care team will occur, to ensure member is referred to appropriate providers of services that are in network (should their provider not be).
   - 1.3. Per the transitions of care OAR 410.141.3061, historical utilization data from the State and previous provider will be submitted to Trillium Community Health Plan in a timely manner in compliance with Federal and State law.
   - 1.4. Members will continue to access to any other necessary procedures as specified by the Secretary of State to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.
2. Transitions of care from one CCO to another CCO rules do not:
   - 2.1. Apply to a member who is dis-enrolled from Medicaid or who has a gap in coverage following disenrollment from the predecessor plan; or
   - 2.2. Require Trillium Community Health Plan to provide care to a member other than as required by the member's enrollment in the CCO.
3. Trillium Community Health Plan:

3.1. Is not responsible for payment of the following services:
  3.1.1. Health related services as defined in OAR 410.141.3150;
  3.1.2. Inpatient hospitalization or post hospital extended care, for which a predecessor CCO was responsible under its contract.

3.2. Remains responsible for care coordination and discharge planning activities in conjunction with others as described in OARs 410-141-3160 and OAR 410-141-3170.

3.3. Trillium shall provide care coordination services to assist members with establishing care in a covered service area, if member requests, provider requests and/or if member is part of a prioritized population, as per 410-141-3061.
  3.3.1. Medically fragile children;
  3.3.2. Breast and Cervical Cancer Treatment program members;
  3.3.3. Members receiving CareAssist assistance due to HIV/AIDS;
  3.3.4. Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and
  3.3.5. 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, as outlined in 410-141-3061.

4. During the transitions of care period, Trillium Community Health Plan shall honor any written documentation of prior authorization of ongoing covered services:
  4.1. In order to obtain ongoing coverage of non-par behavioral health services, prior authorization requests for continuity of care may be submitted to Trillium Community Health Plan by the previous CCO or FFS entity, the Servicing Provider, or the member or authorized representative in accordance with pertinent Trillium Community Health Plan Utilization Management policies and procedures;
  4.2. Trillium Community Health Plan shall not delay service authorization if written documentation of prior authorization is not available in a timely manner;
  4.3. In such instances, Trillium Community Health Plan 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.

5. Trillium Community Health Plan:
  5.1. Covers all prior authorized care to such members for the transitions of care period, which is the greater of the following periods after the effective date of enrollment with Trillium Community Health Plan:
    5.1.1. Honor Prior Authorizations for up to six (6) months for physical and oral health, regardless of whether the Prior Authorization is for a Participating or Non-Participating Provider;

5.1.2. Honor Prior Authorizations for up to six (6) months for Behavioral Health regardless of whether the Prior Authorization is for a Participating or Non-Participating Provider;

5.1.3. Honor Prior Authorizations for prescription drugs for up to six (6) months regardless of whether the prescription drug is on Contractor's PDL; and

5.1.3.1. Exceptions to continued access to care include the following:

5.1.3.1.1. After the minimum or authorized prescribed course of treatment has been completed; or

5.1.3.1.2. If the reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified provider;

5.1.3.1.3. Notwithstanding, Trillium Community Health Plan is responsible for continuing the entire course of treatment with the recipient's previous provider as described in the service-specific continuity of care period situations below:

5.1.3.1.3.1.1. Prenatal and postpartum care;

5.1.3.1.3.1.2. Transplant services through the first-year post-transplant;

5.1.3.1.3.1.3. Radiation or chemotherapy services for the current course of treatment; or

5.1.3.1.3.1.4. Prescriptions with a defined minimum course of treatment which exceeds the continuity of care period.

5.2. Trillium Community Health Plan shall request written documentation as necessary for transitions of care from the following:

5.2.1. The Division's clinical services for members transferring from FFS;

5.2.2. Other CCOs as needed; and

5.2.3. Previous providers with member consent when necessary.

5.3. Per the transitions of care OAR 410.141.3061, the predecessor plan shall comply with requests from Trillium Community Health Plan for complete historical utilization data within seven (7) calendar days of the member's effective date with Trillium Community Health Plan, after request is made from the previous CCO:

5.3.1. Data shall be provided in a HIPAA compliant format to facilitate transitions of care;

5.3.2. The minimum elements provided, which will be provided in state issues file layout formats, are:

5.3.2.1. Current prior authorizations and pre-existing orders;

5.3.2.2. Prior authorizations for any services rendered in the last twelve (12) months;

5.3.2.3. Current physical and behavioral health services provided;

5.3.2.4. List of all active prescriptions;

5.3.2.5. Current ICD-10 diagnosis.

5.3.2.6. Care Plan (if available) and any supplemental data

6. For members continuing to access services through the member's previous provider, Trillium Community Health Plan shall reimburse non-participating providers consistent with OARs at no less then Medicaid fee-for-service rates.

| **REFERENCES** | |
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| Oregon Administrative Rules | 410.120.1295, 410.141.3000, 410-141-3061, 410-141-3150, 410-141-3160, 410.141.3170,410.141.3225, 410.141.3240 |
| Centers for Medicaid and Medicare | 42 CFR 438.62(b), 42 CFR 438.404 |
| CCO 2019 Contract | |
| **Related Materials:** | |

| **ATTACHMENTS:** |
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| **DEFINITIONS:** |
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**REVISION LOG**

| **REVISION** | **DATE** |
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| Created and approved by TOC/COC Workgroup | 7/18/2019 |
| Amended based on TOC rule changes | 10/29/2019 |
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**POLICY AND PROCEDURE APPROVAL**

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.