AttachmentATTACHMENT 16 — Member Transition PlanMEMBER TRANSITION PLAN

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.

Page limits for this Member Transition Plan is 10 pages. Items that are excluded from the page limit will be noted in that requirement.

1. Background and Supporting Sources

As described in Section 5.8 Member Enrollment, OHA will hold an Open Enrollment period for Members in "Choice Areas" of the state. Members in these areas may move from their current plan to another plan during the Open Enrollment period. For purposes of its Application, Applicant should assume that all of its service areas will be Choice Areas.

The Member Transition Plan should describe the process for the safe and orderly transfer of membersMembers to another CCO and receiving membersMembers from another CCO during the open enrollmentOpen Enrollment period. and how the plan will maximize and maintain continuity of care for Members. This includes, but is not limited to, continuity of care with primary and specialty care providersProviders, primary care and Behavioral Health homes, plans of care, prior authorizationsPrior Authorizations, prescription medications, medical case management services, and transportationCase Management Services, and Transportation.

The Member Transition Plan should include specific processes for membersMembers who may suffer serious detriment to their physical and mental health or who are at-risk of hospitalization or institutionalization, if any breakdown in service provisions or access to care were to occur, including services provided by practitionersPractitioners that may not be contracted with the new CCO. OHA considers these populations to include, but not limited to:

- Prioritized Populations;
- Medically fragile children;
- Breast and Cervical Cancer Treatment program membersMembers;
- Members receiving CareAssist assistance due to HIV/AIDS;
- Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services;
- Members discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health programs in the last 12 calendar months; and
- Members participating in Oregon's CMS approved 1915 (k) and 1915 (c) programs for individuals who have met institutional level of care requirements in order to access Home and Community-Based Services (HCBS) under these federal authorities. These individuals are at risk of institutionalization or would require services in an institution within 30 days. Institution is defined as hospital, nursing facilityHospital, Nursing Facility or intermediate care facility for individuals with intellectual disabilities.

A successful Member Transition Plan will result in a seamless transition experience for Members changing CCOs during the Open Enrollment period, with minimal and ideally no disruptions of care.

OHA will inform Applicants, in connection with RFA awards, which of its service areas are likely to be Choice Areas. In light of that information, Applicants are expected to submit an initialcomplete Member Transition Plan (not subject to the page limits of this RFA), gain OHA approval of its Plan, and update

the ~~plan~~Plan as part of negotiation activities, ~~final awards~~contracting, and Open Enrollment period processes.

2. Plan Contents

a. Coordination between Transferring and Receiving CCOs

OHA expects the Transferring and Receiving CCOs to work together and cooperate to achieve a successful transition for Members who change CCO during the Open Enrollment period.

This section should describe the Applicant's plan to coordinate with other CCOs as the Transferring and/or Receiving CCO. This include but is not limited to establishing working relationships and agreements between CCOs to facilitate data sharing and validation, ~~member prior authorization~~Member Prior Authorization history, ~~provider~~Provider matching and ~~assignment~~Assignment, continuity of care and customer support.

b. Transferring CCOs with Outgoing Members

~~If Applicant does not have a 2019 CCO contract, and therefore will not transfer members to another CCO during the Open Enrollment period, this~~This section of the Member Transition Plan is required ~~only~~ if Applicant (1) has a 2019 CCO contract, (2) is a risk-accepting entity or ~~affiliate~~Affiliate of a 2019 CCO, or (3) has a management services agreement with or is under common management with a 2019 CCO.

(1) Data Sharing

This section should describe the plan to compile and share electronic health information regarding the Member, their treatment and services. Include data elements to be shared, formatting and transmittal methods, and staffing/resource plans to facilitate data transfers to the Receiving CCO(s).

(2) Provider Matching

This section should describe the methods for identifying Members' primary care and Behavioral Health home ~~providers~~Providers and any specialty ~~providers~~Providers, and transmitting that information to the Receiving CCO(s).

(3) Continuity of Care

This section should describe plans to support Member continuity of care, including but not limited to ~~prior authorizations~~Prior Authorizations, prescription medications, medical ~~case management services, and transportation~~Case Management Services, and Transportation. This section should include all ~~members~~Members regardless of health status with specific details to address those ~~members~~Members at risk as described in Section (1).

c. Member/Provider Outreach for Transition Activities

This section should describe plans to work directly with outgoing Members and their ~~providers~~Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping ~~members~~Members and ~~providers~~Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Receiving CCO to ensure a seamless transition of care for the ~~member~~Member.

d. Receiving CCOs with Incoming Members

(1) Data Sharing

This section should describe the data reception plan for incoming Members, including but not limited to receiving and storing data files, front-end validation, system entry, output validation, and distribution.

(2) Provider Matching

This section should describe the methods for identifying Members' primary care and Behavioral Health home ~~providers~~Providers and any specialty ~~providers~~Providers, and enrolling Members with their assigned ~~providers~~Providers. This includes contingency plans for assigning Members to appropriate ~~providers~~Providers if they cannot be enrolled with the ~~provider~~Provider from the Transferring CCO.

(3) Continuity of Care

This section should describe plans to support Member continuity of care, including but not limited to honoring ~~prior authorizations~~Prior Authorizations, prescription medications, and ~~treatment plans~~Treatment Plans from the Transferring CCO, medical ~~case management services, and transportation~~Case Management Services, and Transportation. This section should address the approach for all ~~members~~Members regardless of health status with specific details to address those persons described in Section (1). As the receiving CCO, the plan should address how the ~~receiving~~Receiving CCO will ensure access to all medically necessary services for ~~members~~Members at risk of serious detriment to their physical and mental health, hospitalization, or institutionalization.

(4) Member/Provider Outreach for Transition Activities

This section should describe plans to work directly with incoming Members and their ~~providers~~Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping ~~members~~Members and ~~providers~~Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Transferring CCO to ensure a seamless transition of care for the ~~member~~Member.

3. Reference Documents:

- 2019 Contract Extension, Contract Termination and Closeout Requirements
- OAR 410-141-3061 Transition of Care Requirements
- OAR 410-141-3258 Contract Termination and Closeout Requirements
- Oregon's K Plan web page
- Oregon's Application for a 1915(c) HCBS Waiver

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