OFFICE OF THE SECRETARY OF STATE
DENNIS RICHARDSON
SECRETARY OF STATE

LESLIE CUMMINGS
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
MARY BETH HERKERT
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

PERMANENT ADMINISTRATIVE ORDER

FILED
12/26/2018 11:55 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

DMAP 117-2018
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: New CCO Rule on Transition of Care Requirements

EFFECTIVE DATE: 01/01/2019

AGENCY APPROVED DATE: 12/26/2018

CONTACT: Sandy Cafourek
503-945-6430
sandy.c.cafourek@dhsoha.state.or.us

500 Summer St. NE
Salem,OR 97301

Filed By:
Sandy Cafourek
Rules Coordinator

ADOPT: 410-141-3061

RULE TITLE: Transition of Care Requirements

NOTICE FILED DATE: 11/06/2018

RULE SUMMARY: The Authority is required under 42 CFR 438.62 to have a transition of care policy for CCOs that ensures continued access to services during a transition from Fee-for-Service to a CCO or transition from one CCO to another. The effective compliance date for the State of Oregon is January 1, 2019.

RULE TEXT:

(1) This rule applies to care of a Medicaid member who is enrolled in a CCO (the "receiving CCO") immediately after the disenrollment of the member from another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or from Medicaid fee-for-service (FFS). Both instances shall be considered as the predecessor plan. This rule does not:

(a) Apply to a member who is disenrolled from Medicaid or who has a gap in coverage following disenrollment from the predecessor plan;

(b) Require the receiving CCO to provide care to a member other than as required by the member's enrollment in the CCO.

(2) Definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Health Systems Division (Division) administrative rules, applicable to the medical assistance program. This rule does not include an exhaustive list of Division definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-3000 Acronyms and Definitions and 410-200-0015 General Definitions:

(a) "Continued Access to Care" means the receiving CCO provides access to medically necessary covered services and care coordination without delay during a member's transition of care;

(b) "Prior Authorized Care" means covered services authorized by the predecessor plan. CCOs are responsible for providing continued access to care during a transition of care, consistent with applicable federal and state law, to members described in section (3). The receiving CCO must cover all prior authorized care to such members for the transition of care period defined in (5) and (6) until the CCO is able to develop an evidence-based, medically appropriate care plan;

(c) “Receiving CCO” means the CCO remains responsible for identifying persons in need of integration and care coordination as required in OAR 410-141-3160 and intensive care coordination services under OAR 410-141-3170 Intensive Care Coordination Services and the provision of both services as appropriate;
(d) “Transition of Care” means continued access to services during a member’s transition from a predecessor plan to the receiving CCO.
(3) CCOs must implement and maintain a transition of care policy that at a minimum meets the requirements defined in this rule and 42 CFR 438.62(b). A receiving CCO must provide transition of care to, at minimum, 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.
(4) The receiving CCO:
(a) Is not responsible for payment of the following services:
(A) Health related services as defined in OAR 410-141-3150;
(B) Inpatient hospitalization or post hospital extended care, for which a predecessor CCO was responsible under its contract.
(b) Remains responsible for care coordination and discharge planning activities in conjunction with others as described in OAR 410-141-3160 and OAR 410-141-3170.
(5) The transition of care period is the greater of the following periods after the effective date of enrollment with the receiving CCO:
(a) Thirty days for physical and oral health and sixty days for behavioral health or until the enrollee'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) Ninety days for members who are dually eligible for Medicaid and Medicare.
(6) During the transition of care period, the receiving CCO shall ensure that any member identified in section (3) has continuing access to care as defined in (2)(a) previously authorized and is permitted to retain the member’s previous provider, regardless of CCO provider participation except for the following:
(a) After the minimum or authorized prescribed course of treatment has been completed; or
(b) If the reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified provider;
(c) Notwithstanding section (6)(a) and (b), the receiving CCO 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:
(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 continuity of care period.
(d) Where this section (6) allows the member to continue using the member’s previous provider, the receiving CCO shall reimburse non-participating providers consistent with OAR 410-120-1295 at no less then Medicaid fee-for-service rates.
(7) A receiving CCO shall obtain written documentation as necessary for transition of care from the following:
(a) The Division’s clinical services for members transferring from FFS;
(b) Other CCOs as needed; and
(c) Previous providers with member consent when necessary.
(8) During the transition of care period, a receiving CCO shall honor any written documentation of prior authorization

of ongoing covered services:
(a) CCOs shall not delay service authorization if written documentation of prior authorization is not available in a timely manner;
(b) In such instances, the CCO 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.
(9) The predecessor plan shall comply with requests from the receiving CCO for complete historical utilization data within 21 calendar days of the member's effective date with the receiving CCO:
(a) Data shall be provided in a HIPAA compliant format to facilitate transitions of care;
(b) 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 diagnosis.
(10) The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3225 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 410-141-3240.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.065