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TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 41-2026

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

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ARCHIVES DIVISION SECRETARY OF STATE & LEGISLATIVE COUNSEL

FILING CAPTION: Changes from comprehensive review of Transition of Care rule prior to Healthier Oregon Transition

EFFECTIVE DATE: 10/01/2026 THROUGH 03/29/2027

AGENCY APPROVED DATE: 09/30/2026

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NEED FOR THE RULE(S):

While such rule changes affecting transitions of care for OHP members between coordinated care organizations (CCOs), or between CCOs and OHP Open Card would normally be able to go through the permanent rulemaking process, federal requirements will mean that approximately 100,000 members who have OHP through Healthier Oregon will be moving from enrollment in a CCO to OHP Open Card on January 1, 2027.

JUSTIFICATION OF TEMPORARY FILING:

(1) Describe the specific consequences that result from the failure to immediately adopt, amend or suspend the rule(s):
The transition of this large of a population could result in a loss of continuity of care for the a significant number of OHP members affected, especially those members at high risk who may experience adverse health outcomes if their care is interrupted.

(2) Who would suffer these consequences:
Healthier Oregon Program members who will be transitioning to OHP Open Card on 1/1/2027 and the CCOs, OHP providers and OHA staff and other contractors that serve to manage their care.

(3) Why or how failure to immediately take rulemaking action would cause these consequences:
OHP members, especially those at high risk, could lose contact with existing providers that are not enrolled in OHP Open Card, causing them to forego necessary health care that could lead to unnecessary consequences to their health, including hospitalization. CCO, OHP providers and OHA staff would not have rules in place to provide direction on steps to take to prevent such outcomes.

(4) How the temporary action will avoid or mitigate those consequences:
By having the rule changes in place 90 days before the Health Oregon Transition date, affected OHP member, CCOs, providers and OHA staff will be able to better make preparations to make the transition go as smoothly as possible.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

AMEND: 410-141-3850

RULE SUMMARY: Changes resulting from a comprehensive review of the Transition of Care rule that: 1) Expands the rule to include members transitioning from CCOs to OHP Open Card, 2) Standardizes the transition of care period for all members to 90 days, 3) Provides continued access to services to all members, when possible, 4) Clarifies responsibilities for the predecessor entity and receiving entity related to such things as care coordination, notifications, and the exchange of data, and 5) Identifies requirements specific to large transitions involving 500 or more members. Replace references to a “member” with “CCO Member” where appropriate.

CHANGES TO RULE:

410-141-3850
Transition of Care
(1) ~~This rule applies to care of a Medicaid member who is 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). This rule does not apply to a member who is ineligible for Medicaid or who has a gap in coverage following disenrollment from the predecessor plan.¶~~
~~(2) For purposes of this rule, the following additional definitions apply~~For purposes of this rule, the following definitions apply in addition to those found in OAR 410-120-0000 and 410-141-3500:¶
(a) "Continued Access to Services" means making available to the ~~m~~Member, to the highest degree possible, those services, prescriptions, 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;¶~~
~~(b) "Medically Fragile Children (MFC)" as defined by OAR 411-300-0110 means children that have a health impairment that requires long-~~;¶
(b) "Predecessor Entity" means the healthcare delivery system, either a CCO or OHP Open Card, that an OHP Member is leaving. This can be another CCO after disenrollment resulting from the term~~, intensive, specialized service~~ination of the predecessor CCO's con~~a daily basis, who have been found eligible for MFC services by the Department of Human Services (DHS);~~tract.¶
(c) "Receiving Entity" means the healthcare delivery system, either a CCO or OHP Open Card, that an OHP Member is joining.¶
(~~c~~d) "Transition of Care Period" means the period ~~of time after the effective date of~~beginning on the Member's enrollment date with the receiving ~~CCO~~entity, during which the receiving ~~CCO~~entity must provide ~~c~~Continued ~~a~~Access to ~~s~~Services. The ~~t~~Transition of ~~c~~Care ~~p~~Period lasts for~~:¶~~
~~(A) Ninety (~~ 90~~)~~ days for ~~members who are dually eligible for Medicaid and Medicare; or¶~~
~~(B) For other members, the shorter of:¶~~
~~(i) Thirty (30) days for~~all Members and for all physical ~~and~~, oral ~~health and sixty (60) days for behavioral health; or¶~~
~~(ii) Until the enrollee's new PCP~~and behavioral health services unless either of the following apply:¶
(A) The Member's new primary care provider (oral or behavioral health provider, as applicable to medical care or behavioral health care services) reviews the member's treatment plan~~;~~ within 90 days o~~r~~f the ~~minimum or~~

~~authorized prescribed course of treatment has been completed.¶~~
~~(3) CCOs shall 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 continued access to services to, at minimum, the following members:¶~~
~~(a) Medically Fragile Children (MFC);¶~~
~~(b) Breast and Cervical Cancer Treat~~transition date; or¶
(B) Notwithstanding paragraph (A) of this subsection (b), a prescribed course of treatment has been authorized beyond 90 days of the transition date per subsection (e) of section (4) this rule.¶
(2) This rule applies to care of an OHP Member who is enrolled with a Receiving Entity after disenroll~~pf~~ment ~~rogram members;¶~~
~~(c) Members receiving CareAssist assistance due to HIV/AIDS;¶~~
~~(d) Members receiving services for end stage renal disease, prenatal or postpartum ca~~m a Predecessor Entity. For Members transitioning from one CCO to another, this rule only applies to Members with ongoing OHP eligibility who have not had an enrollment gap of mo~~re, transpl~~han~~t se~~rvices (including pre-transplant and post-transplant services), radia~~ven (7) days following disenrollment from a CCO.¶
(3) The Receiving Entity must implement and maintain a transition~~, orf chemotherapy services; and¶~~
~~(e) Any members who, in the absence of c~~are policy that, at a minimum, meets the requirements of this rule and 42 CFR § 438.62(b). A Receiving Entity must provide Continued ~~a~~Access to ~~s~~Services~~, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization~~ to its Members.¶
(4) During the Transition of Care Period the ~~r~~Receiving ~~CCO shall~~Entity must ensure that ~~any member identified in section (3) of this rule~~each Member:¶
(a) Is provided with Continued Access to Services and ~~has~~the support necessary to access those services such as Non-Emergen~~cy~~t Medical Transportation (NEMT);¶
(b) ~~Is permitted to~~May continue receiving services from the ~~m~~Member's previous ~~p~~Provider;¶
(A) When the Receiving Entity is a CCO, regardless of whether the ~~p~~Provider participates in the receiving CCO's network;¶
(~~c~~B) ~~Is referred to appropriate providers of services that are in the network at the duration of~~When the Receiving Entity is OHP Open Card and when the provider is enrolled as a FFS provider;¶
(c) Is referred to appropriate in-network providers during the Transition of Care ~~p~~Period;¶
(d) ~~Notwithstanding section (4)(b) of this rule, the receiving CCO is responsible for continuing~~Receives health-related social needs (HRSN) benefits in accordance with HRSN transition guidelines outlined in OAR 410-120-2000;¶
(e) Receives the entire course of treatment with the ~~recipient~~Member's previous ~~p~~Provider ~~as described in the following service-specific t~~, even if it extends beyond the Transition of ~~c~~Care ~~p~~Period, in the following situations:¶
(A) Prenatal and postpartum care;¶
(B) Transplant services through the first~~-~~ year ~~post-~~after transplant;¶
(C) Radiation therapy or chemotherapy services for the current course of treatment;~~ or~~¶
(D) Prescriptions with a defined minimum course of treatment that exceeds the ~~t~~Transition of ~~care period~~Care Period;¶
(E) Behavioral health services until an equivalent level of care can be established; or¶
(F) Services provided in an acute care facility other than a hospital and those treatment settings described in OAR 410-141-3815 (e.g., a skilled nursing facility).¶
(~~e~~f) Whe~~re section (4) of this rule allows the m~~n identified as high risk in accordance with OAR 410-141-3865:¶
(A) Receives care coordination between the Predecessor and Receiving Entities that must:¶
(i) Include timely exchange of relevant clinical, care management, and utilization information;¶
(ii) Ensure continuity of care, including active care plans, authorizations, and any other documents necessary to maintain uninterrupted services;¶
(iii) Begin prior to the transition date and continue as needed throughout the Transition of Care Period to prevent gaps in services or care disruptions.¶
(B) Is provided a warm handoff that includes one of the following:¶
(i) A direct communication (e.g., email, letter, telehealth visit) between the Member and any community providers or healthcare providers; or¶
(ii) Facilitation by a transitional care team that supports the Member and bridges the connection and discharge transition planning between the hospitals, predecessor entity, healthcare providers and community providers.¶
(g) When this section allows the Member to continue using the ~~m~~Member's previous ~~p~~Provider, the receiving CCO ~~shall~~must reimburse non-participating providers consistent with OAR 410-120-1295 and at no less than Medicaid fee-for-service rates~~;¶~~
~~(f) The receiving CCO~~ and with no requirement to pay out-of-network rates to providers not in-network for the receiving CCO;¶

(5) When permissible by federal law, the Receiving Entity is not financially responsible for a continuous inpatient hospitalization, or for other treatment settings described in OAR 410-141-3815, for which a ~~p~~Predecessor ~~CCO~~Entity was responsible ~~under its c~~(e.g., under a CCO Contract~~,~~ in accordance with OARs 410-141-3500, 410-141-3710, and 410-141-3805~~.~~);¶
(~~5~~6) ~~After the Transition of Care Period ends, the receiving CCO remains responsible for care coordination and discharge planning activities as described in OAR 410-141-3860 and OAR 410-141-3870.~~The receiving CCO will honor prior authorizations from the Predecessor Entity:¶
(a) For six (6) months after the transition date; or¶
(b) For a minimum of 90 days after the transition date for any ongoing course of medication; or¶
(c) Excluding an ongoing course of medication per subsection (b) of this section (6), until the receiving entity reviews the Prior Authorization and determines a modification in coverage is necessary according to their policies. In making such a determination, the receiving CCO must follow all service authorization protocols in OAR 410-141-3835 and provide the CCO Member with written notice that complies with 42 CFR 438.404 and OAR 410-141-3885 of any decision to:¶
(~~6~~A) ~~The Predecess~~Deny a service authorization request;¶
(B) Authorize a service in an amount, duration, or scope that is less than requested;¶
(C) Reduce a previously authorized service.¶
(7) For ~~P~~lan ~~shall fully and timely comply with request for historical utilization data~~ event-triggered transition that involves 500 or more OHP Members, including but not limited to those resulting from state or federal policy changes, system transitions, or operational disruptions:¶
(a) The Authority reserves the right to issue additional guidance to facilitate a member-centered transition;¶
(b) The receiving entity may use the Predecessor Entity's risk assessments for the purpose of transition of care activities.¶
(c) When the Authority is the Receiving Entity, the Authority will honor prior authorizations from the predecessor CCO for six (6) months after the transition date or until the Authority reviews the Prior Authorization and determines a modification in coverage is necessary;¶
(d) The Predecessor Entity must:¶
(A) Maintain adequate staffing, service access, and care coordination functions through the final day of its responsibility for the Member. The predecessor plan must not reduce or terminate staffing or services in a manner that disrupts continuity of care through the Member's transition;¶
(B) In cases involving plan closures, provide the following notifications:¶
(i) Member notice of plan closure 60 days before the transition of care date;¶
(ii) Tribal member notice of pla~~n~~d cl~~inical records~~osure 60 days before transition of care date;¶
(iii) Provider notification of plan closure.¶
(8) The Predecessor Entity must provide relevant clinical, care management, and utilization information within seven (7) calendar days of the request from the ~~r~~Receiving ~~CCO.~~¶
~~(a) CCOs shall~~Entity.¶
(a) The Receiving Entity must not delay the provision of services if ~~historical utilization data and clinical records is~~relevant clinical, care management, and utilization information are not available in a timely manner~~;~~¶
~~(b).~~ In such instances, the ~~CCO is required to approve claim~~Receiving Entity must approve claims for covered service~~s~~ for which it has not received ~~no historical utilization data and clinical records~~relevant clinical, care management, and utilization information during the ~~t~~Transition of ~~c~~Care ~~time p~~Period, as if the covered services were prior authorized~~. CCOs shall~~;¶
(b) The receiving CCO must 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 the CCO's records about the current member.~~¶
(c) CCOs must comply with the process established by the Authority for the electronic exchange of relevant clinical, care management, and utilization information between the Authority and CCOs for transitions involving OHP Open Card Members. The Authority must provide the details about the process and guidance to assist CCOs in complying with the process through one or more documents made available on the CCO Contract Forms webpage at https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.¶
(d) The receiving CCO must incorporate the information received from the Predecessor Entity into the CCO Member's clinical and administrative records.¶
(e) With the approval and at the direction of a current or former ~~enrollee or the enrollee's personal r~~member or the Member's Representative, the ~~CCO~~Receiving Entity must:¶
(A) Receive and process all such data for a current ~~m~~Member from any other payer that has provided coverage to the ~~enrollee~~Member within the preceding ~~5~~five (5) years;¶
(B) ~~At any time the member is currently enrolled in CCO and up to 5~~While a Member is enrolled with the Receiving Entity and for up to five (5) years after disenrollment, send all such data to any other payer that currently covers

the ~~enrollee~~Member or a payer the ~~enrollee or the enrollee's personal r~~Member or the Member's Representative specifically requests to receive the data; and¶
(C) Send data received from another payer under this ~~paragraph~~subsection in the electronic form and format it was received.¶
(~~7~~9) ~~The receiving CCO shall follow all service authorization protocols outlined in OAR 410-141-3835 and give~~In addition to the notices required under 42 CFR 438.404, the Receiving Entity must provide notification of the following:¶
(a) A plain-language written notice at enrollment or as soon as the Transition of Care Period begins. This notice must explain the ~~m~~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~~'s rights to Continued Access to Services during the Transition of Care Period, including the right to continue services with the Member's previous Provider as provided by this rule, and any other protections under this rule.¶
(b) Member pharmacy coverage changes;¶
(c) Drug benefit changes and Prior Authorization coverage;¶
(d) Member disruption to mail order pharmacy services.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.065