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Department: Benefit Management & Pharmacy Services	
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Line(s) of Business: AllCare CCO, Inc.	
Affected Department(s): Benefit Management & Pharmacy Services	
Approved By: Chief Medical Officer **Date Approved :** 03-07-2019 **Oversight By:** Subcategories of Oversight not selected.	

KEY WORDS: Formerly UM CCO 129

POLICY STATEMENT

Oregon Administrative Rule 410-141-3850, CFR 438.62, 411-300-0110, 410-120-1295, OAR 410-141-3500; 410-141-3710, 410-141-3805, 410-141-3885

PURPOSE

To outline the policy and procedure for applying the OAR Transition of Care Requirements to our members who are enrolled in AllCare CCO immediately after disenrollment from another CCO (including disenrollment resulting from termination of the predecessor CCO's contract) or Medicaid fee-for-service (FFS). This policy does not apply to a member who was ineligible for Medicaid prior to enrolling in AllCare CCO or who has a gap in coverage following disenrollment from the predecessor plan.

RESPONSIBILITY: Benefit Management & Pharmacy Services, BMPS Compliance

DEFINITIONS

New Enrollee is defined as an OHP member who is enrolled onto AllCare CCO who had prior enrollment in Fee-for-Service or other CCO without a gap in enrollment.

Receiving CCO means AllCare CCO.

Transition of Care means making available to the member 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.

Medically Fragile Children (MFC) as defined by OAR 411-300-0110 means children that have a health impairment that requires long-term, intensive, specialized services on a daily basis, who have been found eligible for MFC services by the Department of Human Services (DHS);

Transition of Care Period means the period of time after the effective date of enrollment with the receiving CCO, during which the receiving CCO must provide continued access to services.

POLICY

1. AllCare CCO will provide transition of care to our newly enrolled members.

    a. Transition of Care period will last for:
        i. 90 days for members who are dually eligible for both Medicaid and Medicare; or
        ii. For other member the shorter of one of the following:
            1. Thirty (30) days for physical and oral health and 60 days for behavioral health; or
            2. Until the enrollees PCP (Oral or behavioral health provider, as applicable to medical care or behavioral healthcare services) reviews the member's treatment plan; or
            3. The minimum or authorized prescribed course of treatment has been completed.
    b. The following members must be provided continued access to services previously received by the prior CCO or FFS during transition of care:
        i. Medically fragile children;
        ii. Breast and Cervical Cancer Treatment program members;
        iii. Members receiving CareAssist assistance due to HIV/AIDS;
        iv. Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services (pre-transplant and post-transplant), radiation, or chemotherapy services;
        v. 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.

2. During the transition of care period, any identified eligible member classified as meeting an element of section (b)
    a. Will have continuing access to care previously authorized; and
    b. Is permitted to retain the member's previous provider, regardless of CCO provider participation; and

c.H as support necessary to access those services such as Non-Emergent Medical Transportation (NEMT).

3. AllCare CCO, the receiving CCO, is responsible for continuing the entire course of treatment with the member'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.R adiation 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.
4. Where sections (2 and 3) of this rule 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.
5. After the transition of care period ends, the receiving CCO remains responsible for Care Coordination and discharge planning activities described in OAR 410-141-3860, 410-141-3870.
6. The following services are NOT covered under transition of care:
    a. Health related services as defined in OAR 410-141-3850;
    b. Inpatient hospitalization or post hospital extended care, defined as a continuous stay, for which a predecessor CCO was responsible under its contract. OAR 410-141-3500; 410-141-3710, 410-141-3805

7. AllCare CCO follows the protocols outlined in 410-141-3835 and will 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 410-141-3885.

Transition of care eligible members:

1. New eligible members will be granted continued access to services at minimum:
    a. 30 days for Physical and/or Oral Health
    b. 60 days for Behavioral Health
    c.9 0 days for members who are dually eligible for Medicaid and Medicare.
2. Members are identified with a "TOC flag" as a member condition code with the date range associated with the TOC eligibility.

PROCEDURES

1. Pharmacy claims, please see Pharmacy department policy.
2. Medical claims, please see Claims department policy.
3. Authorizations:
    a. Pre-Service and Post-Service

b. Upon service authorization request, if a member is identified to be within the transition period the member may be granted transition of care access for OHP covered medical care services and any enrolled OHP Provider, even if non-contracted, based on the following:
    i. Physical health, Oral health and Pharmacy services:
        1. Member is not eligible for Medicare (see #3 for dual eligible).
        2. Non-eligible services include:
            a. Inpatient hospitalization or post hospital extended care for which the predecessor plan is responsible
            b. Health Related Services
            c. OHP Excluded services
        3. Verification of coverage:
            a. Determine if service is OHP covered
        4. Once the above criteria is met, any identified member will have continuing access to care and is permitted to retain the member's previous provider, regardless of CCO provider participation during the transition of care period. Analyst may approve per scope:
            a. The following services will be covered beyond the TOC period:
                i. Radiation therapy or chemotherapy through the current course of therapy,
                ii. Pre-natal care and/or post-partum care
                iii. Prescriptions with a defined minimum course of treatment that exceeds the continuity of care (e.g. treatment of an infection where the course of treatment is 6 months)
                iv. Transplant services will be approved through the first year of post-transplant care.
    ii. Behavioral Health services – Mental Health and Substance Use Disorders
        1. Member is not eligible for Medicare (see #3 if yes).
        2. Non-eligible services include:
            a. Inpatient hospitalization or post hospital extended care for which the predecessor plan is responsible
            b. Health Related Services
            c. Carved-out services such as 7-11 medications
        3. Verification of coverage:
            a. Determine if service is OHP covered
        4. Once the above criteria is met, any identified member will have continuing access to care previously authorized and is permitted to retain the member's previous provider, regardless of CCO provider participation during the transition of care period.
    iii. Dually eligible for Medicaid and Medicare

1. Non-eligible services include:
    a. Inpatient hospitalization or post hospital extended care for which the predecessor plan is responsible
    b. Health Related Services
    c. OHP Excluded Services
2. Verification of coverage:
    a. Determine if service is OHP covered
3. Once the above criteria is met, any identified member will have continuing access to care previously authorized and is permitted to retain the member's previous provider, regardless of CCO provider participation during the transition of care period. Analyst may approve per scope.
4. The following services will be covered beyond the TOC period:
    a. Radiation therapy or chemotherapy through the current course of therapy,
    b. Pre-natal care and/or post-partum care
    c. Prescriptions with a defined minimum course of treatment that exceeds the continuity of care (e.g. treatment of an infection where the course of treatment is 6 months)
    d. Transplant services will be approved through the first year of post-transplant care.

OVERSIGHT & MONITORING

This Policy and Procedures will be reviewed annually by Benefit Management and Pharmacy Services to ensure alignment with best practices and all applicable rules, regulations and contact requirements.

REPORTING

No reporting to list at this time.

SUPPORTING POLICIES

UMCCO TOC Data Requests
UM CCO RX TOC