MEDICAL POLICY STATEMENT
GEORGIA MEDICAID

Original Issue Date	Next Annual Review	Effective Date
07/24/2017	05/15/2019	05/15/2018
Policy Name		**Policy Number**
Transition of Members-Long Term Care		MM-0099
Policy Type		
MEDICAL	Administrative / Pharmacy	Reimbursement

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

Contents of Policy

A. SUBJECT

Transition of Members—Long Term Care

B. BACKGROUND

Transition of Members—Long Term Care is the attentiveness to the delivery of quality care over time and during certain network transitions, typically outside the direct control of a member. The goal is in the delivery of consistent healthcare services through proper coordination combined with information sharing among providers to enhance a patient focused approach.

C. DEFINITIONS

- Nursing Homes: A private facility to care for members who do not require acute hospitalization but cannot be cared for at home
- Skilled Nursing Facilities: A facility that provides skilled inpatient nursing and related services to a member that requires rehabilitative care
- Discharge Planning: : Utilized to assist the provider in coordinating the member's discharge when long term care is no longer necessary
- Transition of care period: Allows a member to continue a prior approved and/or active course of treatment during a transition period. Transition periods occur when there is a change in the plan's benefit coverage, a change in a provider's status, or during enrollment into the plan The transition of care period is typically <<30/60/90>> days except in the case of maternity care, oncology treatment, or transplant services, in which the period may be extended longer

D. POLICY

I. Transition of members provides newly enrolled members meeting specific criteria continued care with a former, non-participating provider, including Nursing Homes, Skilled Nursing Facilities, Psychiatric Residential Treatment Facilities and other facilities that offer long term non-acute care during transition to a participating provider. Transition of members also may apply to existing members who are impacted when a participating terminate their agreement with CareSource. In order to ensure care is not disrupted or interrupted, the transition of members process becomes a "bridge of coverage" allowing members to transition from their old plan to CareSource or from a terminated provider to a CareSource participating provider. Qualification requires the following:
   A. You must have been receiving covered services from the non-participating provider at the time of the change in health plans
      OR
   B. You must have been receiving covered services from the terminated provider on the effective date of contract termination

II. CareSource will coordinate COC for members with existing and uncompleted care treatment plans that include scheduled services with non-participating providers or who transition to or from another health plan including members with special health care needs.

E. CONDITIONS OF COVERAGE

Upon disenrollment from CareSource, the financial responsibility for services provided to the Member transitions to the Member's new CMO or Fee-for Service Medicaid.

Members who are in ongoing non-acute treatment in an inpatient facility that has been covered by DCH or another CMO prior to their new CMO effective date will be covered by CareSource for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary transition of care.

CareSource will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days. (Age, blind, and

disabled not included in managed care-change in circumstance where category and unenrolled in plan. Until DCH changes category of age, they will be covered up to (30) days. Transition to LTC.)

HCPCS
CPT
AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

N/A

G. REVIEW/REVISION HISTORY

DATES		ACTION
Date Issued	07/24/2017	New Policy.
Date Revised		
Date Effective	05/15/2018	

H. REFERENCES

1. Gulliford, M., Naithani, S., & Morgan, M. (2006). What is "continuity of care"? *Journal of health services research & policy. 11*(4), 248–50. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17018200
2. Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: A multidisciplinary review. , *327*(7425), . Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC274066

Transition of Members - Long-Term Care Coverage Responsibility: Members enrolled in a CMO who are receiving services in a long-term care facility will remain the responsibility of the admitting CMO until disenrolled from the CMO by DCH.	The CMO shall: 1. Provide its policies and procedures for its long-term care coverage responsibility	For the purposes of this requirement, long-term care facilities include Nursing Homes, Skilled Nursing Facilities, Psychiatric Residential Treatment Facilities and other facilities that provide long-term non-acute care. Upon disenrollment from the CMO, the financial responsibility for services provided to the Member transitions to the Member's new CMO or Fee-for Service Medicaid. Members who are in ongoing non-acute treatment in an inpatient facility that has been covered by DCH or another CMO prior to their new CMO effective date will be covered by the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary transition of care. The CMO will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days. (Age, blind, and disabled not included in managed care-change in circumstance where category and disenrolled in plan. Until DCH changes category of age, they will be covered up to (30) days. Transition to LTC.)

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.