ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Continuity of Care-OH MCD-AD-0742	02/01/2023
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates 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.

Administrative Policy Statements prepared by CareSource and its affiliates 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 Administrative Policy Statement. If there is a conflict between the Administrative 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Continuity of Care

B. Background

Continuity of Care (COC) provides newly enrolled members meeting specific criteria continued care with a former or non-participating provider, including acute hospitals, during transition to a participating provider. COC may apply to existing members who are impacted when a participating provider, practitioners and general acute care hospitals, terminates an agreement with CareSource. COC may also apply when a newly enrolled member is or will be receiving services for which a prior authorization was received from another payer. In order to ensure care is not disrupted or interrupted, the COC process becomes a bridge of coverage, allowing members to transition from their previous plan to CareSource or from a terminated provider to a CareSource participating provider.

The American Academy of Family Physicians (AAFP) defines COC as the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high-quality, cost-effective medical care.

C. Definitions

- **Acute Condition** - A medical or behavioral health condition involving a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and has a limited duration.
- **Continuity of Care** - A process for assuring that care is delivered seamlessly across a multitude of delivery sites and transitions in care throughout the course of the disease process.
- **Chronic Condition** - A medical or behavioral health condition due to a disease, illness, or other medical problem that is complex in nature and persists without cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
- **Managed Care Organization (MCO)** - A health organization that contracts with insurers or self-insured employers and finances and delivers health care using a specific provider network and specific services and products.
- **Primary Care Provider (PCP)** - A network physician, network physician group, advanced practice nurse or advanced practice nurse group trained in family medicine (general practice), internal medicine, or pediatrics who are responsible for providing and/or coordinating all covered services for network benefits.
- **Participating Provider** - A provider who has entered into a contractual arrangement with CareSource, or another organization that has an agreement with CareSource, to provide certain covered services or certain administration functions for the network associated with the Evidence of Coverage (EOC).
- **Non-Participating Provider** - A provider who has not entered into a contractual arrangement with CareSource, an out-of-network provider.
- **Postpartum Period -** A span of at least 60 days, beginning on the date a woman's pregnancy ends.

- **Terminal Illness -** An illness with a life expectancy of six months or less if the illness runs a normal course.
- **Transition of Care** - A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.

D. Policy

I. CareSource supports COC to ensure consistent healthcare services are delivered through proper coordination combined with information sharing among providers to enhance a patient focused approach. CareSource will honor prior authorizations (PA) that were approved by the member's original Managed Care Organization (MCO) for at least 30 days during transition to CareSource. This includes existing and uncompleted care treatment plans and scheduled services with non-participating providers. COC services may be subject to a medical necessity review. Requests will be accepted from a member or a provider on behalf of a member.

II. COC services will be provided when **ONE** of the following occurs:
   A. When a health partner is terminated from the CareSource network and that termination was not related to fraud or a quality of care issue;
   B. When a newly enrolled member requests continuation of care from the non-participating health partner who was providing care prior to enrollment; or
   C. When a newly enrolled member is or will be receiving services for which a prior authorization (PA) was received from another payer.

III. CareSource ensures that prior authorization requirements are not applied to the following:
   A. Emergency services
   B. Urgent care
   C. Crisis stabilization for behavioral health care
   D. Family planning services
   E. Inpatient substance abuse treatment
   F. Out-of-area renal dialysis services
   G. Communicable disease services, including sexually transmitted infections (STI) and human immunodeficiency virus (HIV) testing
   H. Other services as specified in the Centers for Medicare & Medicaid Services (CMS) - State Memorandum of Understanding (MOU). Members have the option of using an alternative medication without a PA when applicable.

IV. To coordinate care and facilitate transition, COC services will be provided to a participating or non-participating provider and may be subject to a medical necessity review, including the following services:
   A. Continuity of care requests for non-network primary care providers are approved for 30 days of service, allowing the non-network provider time to transfer care to a network primary care provider.
   B. Inpatient care for newborns born on or after their mother's effective date will be the responsibility of the mother's assigned MCO for 90 days after delivery.
   C. Medical hospitalization

D. Members will receive coverage through discharge, including discharge planning and coordination of supplies and services needed following discharge from an institutional clinical setting
E. Inpatient and outpatient behavioral health care. All prior authorizations approved by Medicaid Fee for Service (FFS) will be honored.
F. Extended care or skilled care
When an adult extension member is currently receiving care in a nursing facility on the effective date of enrollment, CareSource will cover the nursing facility care at the same facility until a medical necessity review is completed and, if applicable, a transition to an alternative location has been documented in the member's care plan.
G. Post emergency care
H. Home health services must be covered at the same level with the same provider as previously covered until the MCO conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.
I. Private duty nursing must be covered at the same level with the same provider as previously covered until the MCO conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.
J. Durable medical equipment must be covered at the same level with the same provider as previously covered until the MCO conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5160-26-03.1.

V. COC will be provided when an on-going treatment plan is in place and is subject to a medical necessity review for the following circumstances:
A. Member is receiving behavioral health services within a plan of treatment.
B. Member is receiving covered treatment that is unavailable within the provider network.
C. Member is being treated for a condition that has a finite course of treatment.
D. Pregnancy
1. A COC authorization will be granted for enrolled members who are pregnant and/or have already begun prenatal care with a non-network provider at their effective date. This will be covered through the postpartum period.
2. A COC authorization will be granted for enrolled members with a history of high-risk pregnancy who wish to see a non-network provider who treated them previously for a high-risk pregnancy effective through the postpartum period.
E. Dialysis
F. Chemotherapy and radiation therap when a member has been placed in a chemotherapy and/or radiation treatment plan and until the treatment plan is completed.
G. Major organ transplantation services which are in process, or have been authorized.
H. Surgical care when a member has been placed in a surgical care treatment plan and until that treatment plan is completed, including scheduled inpatient or outpatient surgeries approved and/or pre-certified.
I. Physical therapy, speech therapy, occupational therapy, rehabilitation therapy

J. A member with a condition that involves end-stage disease.
K. A member with an unstable or life-threatening condition.
L. Hospice when a member has been diagnosed with a terminal illness and life expectancy is 6 months or less if the illness runs its normal course.

VI. COC process If a non-participating provider's services meet medical necessity and the COC policy requirements, the non-participating provider will need to sign a single case agreement (SCA).

VII. Continuity of care prior authorization requests for services from non-participating specialists will be determined based on the treatment plan received. When participating providers are not available to provide the needed services after the initial determination, the authorization period may be extended.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATES	ACTION
Date Issued	09/04/2019	
Date Revised	05/26/2021 06/01/2022	Revision to PA requirements. Adjustment to COC coverage expanding pregnancy/newborn/postpartum to 90 days. Added PA not required for family planning services. Editorial revisions.
Date Effective	02/01/2023	
Date Archived		

H. References

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3. Kim JH, Park EC, Kim TH, Lee Y. Hospital charges and continuity of care for outpatients with hypertension in South Korea: a nationwide population-based cohort study from 2002 to 2013. Korean J Fam Med. 2017;38:242–248.
4. Managed health care programs: Primary care and utilization management. Ohio Administrative Code 5160-26-03.1. Retrieved June 17, 2022 from www.ohio.gov.
5. Medicaid medical necessity: definitions and principles. Ohio Administrative Code 5160, 1-1-01. Retrieved on June 17, 2022 from www.ohio.gov.

6. Ohio Department of Medicaid Ohio Medical Assistance Provider Agreement, Effective 07/01/2020 – 06/30/2021.
7. Psychiatric pre-certification review. Ohio Administrative Code 5160-2-40. Retrieved on April 25, 2021 from www.ohio.gov.