ADMINISTRATIVE POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
Continuity of Care-OH MyCare-AD-1384	01/01/2024
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) comprises a series of separate health care services so that treatment remains coherent, unified over time, and consistent with a member's health care needs and preferences. To ensure that care is not disrupted, COC becomes a bridge of coverage, allowing members to transition to CareSource's provider network. Newly enrolled members can continue to receive services by an out-of-network provider when an established relationship exists with that provider, and/or the member will be receiving services for which a prior authorization was received from another payer. Existing members may also utilize COC when a participating provider or acute care hospital terminates an agreement with CareSource. These interventions provided to transitioning members work to promote safety and efficacy.

C. Definitions
- **Continuing Care Patient** - An individual who, with respect to a provider or facility (1) is undergoing a course of treatment for a serious and complex condition from the provider or facility; (2) is undergoing a course of institutional or inpatient care from the provider or facility; (3) is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; (4) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (5) is or was determined to be terminally ill and is receiving treatment for such illness from such provider or facility.
- **Course of Treatment** - A prescribed order treatment for a specific individual with a specific condition that is outlined and decided upon ahead of time between the member and provider and may, but is not required to, be part of a treatment plan.
- **Covered Services** - Medical services set forth in rule 5160-26-03 of the Ohio Administrative Code or a subset of those medical services.
- **Dual Benefits Member (Opt-in Member)** - A member for whom CareSource is responsible for the coordination and payment of Medicare and Medicaid benefits.
- **Home and Community-Based Services (HCBS)** - Service available to individuals to help maintain health and safety in a community setting in lieu of institutional care as described in 42 C.F.R. 440 subpart A (October 1, 2021).
- **Individual Care Plan** - An integrated, individualized, person-centered care plan developed by the member and the trans-disciplinary care management team addressing clinical and non-clinical needs identified in the assessment, including goals, interventions, and expected outcomes.
- **Medicaid Only Member (Opt-out Member)** - A member for whom CareSource is responsible for coordination and payment of Medicaid benefits.
- **Network Provider** - Any provider, group of providers, or entity that has a network provider contract with CareSource to order, refer, or render covered services as a result of a provider agreement or contract.

- **Non-contracting Provider** - Any provider with an ODM provider agreement who does not contract with CareSource but delivers health care services to members.
- **Pending Member** - An eligible individual who has selected or been assigned to CareSource or another managed care entity but membership is not yet effective.
- **Post-stabilization Care Services** - Covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition or under the circumstances described in 42 C.F.R. 422.113 (October 1, 2021) to improve or resolve the member's condition.
- **Primary Care Provider (PCP)** - An individual physician (MD, DO), a physician group practice, an advanced practice registered nurse (APRN), an APRN group practice within an acceptable specialty, or a physician assistant contracting with CareSource to provide services. Acceptable PCP specialty types include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYNs).
- **Serious and Complex Condition** - In the case of (1) an acute illness, a condition serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, a condition that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.
- **Significant Change** - A variation in the health, care or needs of a member that warrants further evaluation to determine if changes to the type, amount or scope of services are needed (i.e., differences in health or caregiver status, residence, location of service, lack of waiver services for 30 days).
- **Terminal Illness** - Medical prognosis of a 6 month or less life expectancy.

D. Policy
   I. CareSource will review COC requests from members or providers/others on behalf of members on a case-by-case basis when **any** of the following occur:
      A. Newly enrolled members will be eligible for CoC services during the first year of enrollment. Thereafter, services may be adjusted following a reassessment with consideration of documented notes, member outcomes, standardized tools, and the CareSource benefit package.
         1. Care is requested from a provider who treated the member prior to enrollment.
            a. When transitioning from Medicaid, CareSource will provide a 90-day transition period to enrollees identified for high-risk care
            b. All others transitioning from Medicaid will receive a 365-day transition period.
         2. Member is or will be receiving prior authorized services from a Medicare or Medicaid payer.
            a. Scheduled surgeries: CareSource will honor the specified provider for any scheduled surgeries.

b. Durable medical equipment (DME): CareSource will honor prior approvals for items not yet delivered and must review ongoing prior authorizations for medical necessity.
c. Chemotherapy/radiation: CareSource will authorize treatment initiated prior to enrollment through the course of treatment with the provider specified in the existing prior authorization.
d. Dialysis treatment: CareSource will provide 90 days of treatment with the same provider and level of service. Before transition to a new provider, the Individualized Care Plan will document successful transition planning to the new provider.
e. Vision and dental: CareSource will honor prior authorizations when an item or service has not been delivered or performed.

B. A network provider is terminated from the CareSource network, and the termination was not related to fraud or a quality-of-care issue. 45 calendar days (CD) before the effective date of the expiration, nonrenewal, or termination of a hospital/facility or PCP contract, CareSource will notify in writing all members in the service area or served by the PCP. If CareSource receives less than 45 CDs notice, notice will be sent within one working day of becoming aware of the expiration, nonrenewal, or termination of the contract.
1. CareSource will prioritize COC for members in their trimesters of pregnancy and/or any receiving chemotherapy or radiation treatment.
2. Member notices will contain contact information for CareSource for further information or assistance. PCP contract termination notices will contain the following additional information, at a minimum:
01. the PCP's name
02. last date the PCP is available to provide care to members
03. information regarding how members can select a different PCP

II. Home and Community-Based Services
A. Medicaid Home Health and Private Duty Nursing
1. For HCBS waiver members, CareSource will maintain the existing service at the level of receipt at the time of enrollment with the current providers and at the current Medicaid rate for 365 calendar days, unless the following occur:
a. a significant change (see definition above)
b. member desire for self-directed services
2. For members not in the HCBS waiver and/or on waiver using the Assisted Living Services, CareSource will continue services with existing providers at the current service level for 90 days. At that time and after an in-person assessment that includes observation of service delivery, CareSource will review services for medical necessity.
3. Members who are in the Assisted Living Waiver or who reside in a nursing facility at the time of enrollment, CareSource will maintain services with the current provider at the current rate for the duration of the demonstration.
B. Direct Care Waiver Services: CareSource will maintain services at the current level for 365 days and with the current providers at the Medicaid rate.

CareSource will change the service provider only after an in-home assessment is completed and a plan for transition to a new provider is in place.

C. Other Waiver Services: CareSource will maintain the service at the current level for 365 calendar days. The existing service provider and the existing rate will be maintained for 90 CDs. CareSource may change the service provider only after an in-home assessment is completed and a plan for transition to a new provider is in place.

III. Behavioral Health Services

Medicaid Community Behavioral Health (BH): CareSource will maintain treatment documented in the BH care plan at the time of enrollment with the current provider at the Medicaid rate and the current level of services for 365 calendar days, following the outlined process below:

A. Historical claims data provided by the State of Ohio will be reviewed to identify BH providers utilized by pending members.
B. The care manager will contact the identified provider(s) to collect current treatment plans and will, then, contact the Medical Management department to address needed prior authorizations for in- and/or out-of-network services.
C. CareSource will work with out of network providers on terms to provide services until a qualified network provider is available.
D. Care managers will inform members and out-of-network providers of specified dates when transition periods will end and if a change in provider and/or service delivery is planned as a result of the availability of in network providers.

IV. Other Services: Some COC services will be subject to medical necessity review. Additional services include the following (not an all-inclusive list):

A. Acute or chronic medical condition course of treatment from an out of network primary care provider will be approved for up to 90 calendar days, allowing the provider time to transfer care to an in-network primary care provider.
B. Institutional clinic settings will be covered through discharge, including discharge planning and coordination of supplies and services needed following discharge.
C. Inpatient and outpatient behavioral health care PAs approved on Medicaid Fee for Service (FFS) will be honored.
D. Pregnancy care will be covered through the postpartum period.
E. Home health services, private duty nursing (PDN) services, and durable medical equipment (DME) will be covered at the same level with the same provider previously covered until CareSource conducts a medical necessity review and renders an authorization decision.
F. Medical hospitalization or post emergency care for members will be covered.
G. Extended care or skilled care for members currently receiving care in a nursing facility on the effective date of enrollment will be covered 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.
H. Members receiving services through the Specialized Recovery Service Program will be allowed to maintain current service levels at the time of enrollment for at

least 180 calendar days after the initial enrollment effective date. After a member's transition period concludes, CareSource will review services for medical necessity.

I. Community transition services for waiver members will be authorized as appropriate and needed in accordance with OAC 5160-44-26.

E. Conditions of Coverage

COC requirements include a process for the inclusion of member data from the electronic exchange of information with other managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans. Data should be included for the previous 5 years, and providers will agree to make records for Medicaid eligible individuals available for transfer to new providers at no cost to the member.

F. Related Policies/Rules

Benefits Coordination
Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	10/11/2023	New policy. Approved at Committee.
Date Revised		.
Date Effective	01/01/2024	
Date Archived		

H. References

1. Confidentiality, OHIO REV. CODE ANN. § 5122.31 (2017).
2. Confidentiality of Records Pertaining to Person's Mental Health Condition, Assessment, Provision of Care or Treatment, or Payment for Assessment, Care or Treatment, OHIO REV. CODE ANN. § 5119.28 (2017).
3. Continued Services to Enrollees, 42 C.F.R. § 438.62 (2023).
4. *Continuity and Coordination of Care: A Practice Brief to Support Implementation of The WHO Framework on Integrated People-Centered Health Services*. World Health Organization; 2018. Accessed July 25, 2023. www.who.int
5. Coordination and Continuity of Care, 42 C.F.R.§ 438.208 (2023).
6. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
7. Managed Care, 42 C.F.R. § 438 (2023).
8. Managed Care: Definition, OHIO ADMIN. CODE § 5160-26-01 (2022).
9. Managed Care: Provider Network and Contracting Requirements, OHIO ADMIN. CODE § 5160-26-05 (2022).
10. Managed Care: Third Party Liability and Recovery, OHIO ADMIN. CODE § 5160-26-09.1 (2022).
11. MyCare Ohio Plans: Definitions, OHIO ADMIN. CODE § 5160-58-01 (2022).

12. Nursing Facility-Based Level of Care Home and Community Based Services Programs: Community Transition Services, OHIO ADMIN. CODE § 5160-44-26 (2020).
13. Ohio Dept of Medicaid (ODM)-Administered Waiver Program: Definitions, OHIO ADMIN. CODE § 5160-45-01 (2020).
14. Services: General Provisions, 42 C.F.R. § 440 (2023).
15. Special Rules for Ambulance Services, Emergency and Urgently Needed Services, and Maintenance and Post-Stabilization Care Services, 42 C.F.R. § 422.113 (2023).