ADMINISTRATIVE POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
Continuity of Care-OH MyCare-AD-1384	02/01/2025
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 of treatment for a specific individual with a specific condition 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.
- **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).
- **Individualized Care Plan (ICP)** – 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.

- **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).
- **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).

D. Policy

I. COC requests from members or providers or others on behalf of members will be reviewed on a case-by-case basis. Members are allowed to maintain current providers and service levels at enrollment as described in section D.II. below. During the transition period, changes from an existing provider may only occur when
   A. a member requests a change
   B. the provider chooses to discontinue services to a member as currently allowed by Medicaid or Medicare
   C. Caresource, Centers for Medicare and Medicaid Services (CMS), or Ohio Department of Medicaid (ODM) identify provider performance issues that affect a member's health and welfare

   Caresource will notify providers and members prior to the end of a transition period if a change in provider and/or service delivery is planned.

II. Coverage Requirements at Enrollment

   The following coverage requirements apply to HCBS waiver members, nonwaiver members with long term care needs (home health [HH] and private duty nursing [PDN] use), nursing facility (NF) & Assisted Living (AL) members, and members not identified for LTC services, unless otherwise specified.
   A. Physician Services: Honored for 90 calendar days (CDs) for members identified for high-risk care management and 365 CDs for all others.
   B. Durable Medical Equipment (DME): CareSource will honor prior authorizations (PAs) when items have not been delivered but will review ongoing PAs for medical necessity.
   C. Scheduled Surgeries: CareSource will honor the specified provider.
   D. Chemotherapy and/or Radiation: Treatment initiated prior to enrollment must be authorized through the course of treatment with the specific provider.
   E. Organ, Bone Marrow, Hematopoietic Stem Cell Transplant: CareSource will honor the specified provider.
   F. Dialysis Treatment: Member will receive 90 CDs with the same provider and level of service. The ICP must document successful transition planning for a new provider.
   G. Vision and Dental: CareSource will honor PAs for items not yet delivered.
   H. Medicaid HH and PDN:

1. HCBS waiver members may maintain service at current levels and with current providers at current medicaid reimbursement rates. Changes may not occur unless
   a. a significant change occurs as defined in OHIO ADMIN. CODE 5160-45-01
   b. member elects to self-direct services
   c. after 365 days
2. Nonwaiver members with LTC needs (HH and PDN use) and AL members may sustain existing services for 90 CDs. A review for medical necessity will occur after an in-person assessment that includes provider observation.

I. Assisted Living Waiver Services: AL members may maintain provider at current rate for life of demonstration.
J. Medicaid NF Services: NF members may maintain provider at current medicaid rate for the life of demonstration.
K. Waiver Services (Direct Care, Personal Care Waiver, Nursing Home Care Attendant, Choice Home Care Attendant, Out of Home Respite, Enhanced Community Living, Adult Day Health Services, Social Work, Counseling, Individual Living Assistance): Member may maintain service at current level and with current providers at current medicaid reimbursement rates. Changes may not occur unless
   1. a significant change occurs as defined in OHIO ADMIN. CODE 5160-45-01
   2. member elects to self-direct services
   3. after 365 days
L. Waiver Services (All Others): Member may maintain service at current level for 365 days and existing service provider at the existing rate for 90 CDs. CareSource initiated changes will occur after an in-home assessment and plan for the transition to a new provider.
M. Medicaid Community Behavioral Health (BH) Organizations (Provider Types 84 & 95): Members may maintain current provider and level of services documented in the BH plan of care at the time of enrollment for 365 CDs. Medicaid rate applies during transition. Inpatient and outpatient BH PAs approved on Medicaid Fee for Service (FFS) will be honored.

III. CareSource will make reasonable efforts to contact out of network providers, including providers and prescribers providing services to members during the initial transition of care period to inform providers that the transition period will end on a specified date and provide information on becoming a credentialed network provider, if CareSource is accepting new applications for that provider type. CareSource may offer single-case agreements to out of network providers until a qualified network provider is available for the member.

IV. CareSource will make good faith efforts to give written notice to members of terminations of provider or facility contracts regardless of whether the termination was for or without cause.
   A. For contract terminations involving PCPs or BH providers at least 45 CDs before the termination date, CareSource will provide members with written notice and

make 1 attempt at telephonic notice, unless the member has opted out of calls, for any member currently assigned to that PCP or BH provider within the past 3 years.

B. For contract terminations involving specialty types other than PCPs or BH providers at least 30 CDs prior to termination effective date, CareSource will provide written notice to all members assigned to, currently receiving care from, or have received care with in the past 3 months.

E. Conditions of Coverage

I. 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.

II. Historical claims data provided by the State of Ohio may be reviewed to identify providers utilized by members.

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	10/23/2024	Annual review. Aligned policy with most recent contract. Updated definitions & references. Approved at Committee.
Date Effective	02/01/2025	
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 (2024).
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 October 9, 2024. 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: Definitions, OHIO ADMIN. CODE § 5160-26-01 (2022).

8. Managed Care: Provider Network and Contracting Requirements, OHIO ADMIN. CODE § 5160-26-05 (2022).
9. Managed Care: Third Party Liability and Recovery, OHIO ADMIN. CODE § 5160-26-09.1 (2022).
10. MyCare Ohio Plans: Definitions, OHIO ADMIN. CODE § 5160-58-01 (2022).
11. Nonrenewal of Contract, 42 C.F.R. §422.506 (2018).
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).