ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Continuity of Care-OH MCD-AD-0742	06/01/2024
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.

Tabzle of Contents

A. Subject

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. COC promotes safety and effective healthcare to transitioning members.

B. 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 (National Committee for Quality Assurance, NCQA).
- **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 insuring corporation licensed in the state of Ohio that enters into a manage care provider agreement with Ohio Department of Medicaid (ODM).
- **Primary Care Provider (PCP)** – An individual physician, physician group practice, advanced practice nurse (APN), APN group practice, or physician assistant trained in family/general practice, internal medicine, pediatrics, or obstetrics/gynecology who are responsible for providing and coordinating all covered services for network benefits.
- **Participating or Network Provider** – Any provider, group of providers, or entity that has a network provider contract with CareSource in accordance with Ohio Administrative Code (OAC) 5160-26-05 and receives medicaid funding directly or indirectly to order, refer, or render covered services.
- **Non-Participating or NonContracting Provider** – Any provider with an ODM provider agreement who does not contract with CareSource but delivers health care services to CareSource members, an out-of-network provider.
- **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 improve or resolve the member's condition.

- **Postpartum Period** – The maximum permitted period of coverage as described in 42 U.S.C. § 1396a(e).
- **Terminal Illness** – A 6-month or less life expectancy if the illness runs a normal course.
- **Transition of Care** – A set of actions designed to ensure coordination and continuity of care as patients transfer between different locations or different levels of care within the same location.

C. Policy

I. CareSource supports COC to ensure that consistent healthcare services are delivered through proper coordination combined with information sharing among providers to enhance a patient focused approach. Requests will be accepted from a member, a member's representative, or a provider on behalf of a member. CareSource follows ODM requirements to facilitate the exchange of member-specific data and ensure facilitiation of care among all stages, including pre-enrollment to enrollment completion. All transitions of care between healthcare settings will be handled according to ODM requirements, including care coordination guidance (ie, Care Coordination Portal), discharge planning, and followup with providers/members.

II. COC services will be provided when **ONE** of the following occur:

A. A provider/facility is terminated from the CareSource network, and the termination was not related to fraud or a quality of care issue. Members served by the provider/facility will be identified to ensure that health, safety, and welfare needs are met (eg, securing informal support). Members will be assisted with selecting a new provider as expeditiously as possible. Clinical record documentation will reflect the member's choice of network provider(s).

B. A newly-enrolled member requests COC from a participating or non-participating health partner who was providing care prior to enrollment in the following circumstances:

1. The member is currently receiving care in a nursing facility on the effective date of enrollment. CareSource will cover 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 person-centered care plan.
2. For members pregnant at enrollment, CareSource will identify the member's maternal risk and facilitate connection to services and supports. COC authorizations will be granted for any pregnant enrolled or newly-enrolled members who are pregnant and/or have already begun prenatal care with a non-network provider at the effective date through the postpartum period, including enrolled members with a history of high-risk pregnancy who wish to see a non-netowrk provider who treated the member previously for a high-risk pregnancy.
3. The member could suffer detriment to health or be at risk for hospitalization or institutionalization in the absence of continued services.

C. Newly enrolled member is or will be receiving services for which a prior authorization (PA) was received from another payer prior to the transition. CareSource will honor PA through its expiration, regardless of whether the authorized or treatment provider is in or out-of-network, but will conduct a medical necessity review for previously authorized services if the member's needs change or warrant a change in service. All decisions will be rendered pursuant to OAC 5160-26-03.1.
   1. CareSource will assist the member in accessing services through a network provider when any of the following occur:
      a. member condition stabilizes and no interruption to services
      b. member chooses to change the current provider to a network provider
      c. identified quality concerns with the previously authorized provider
   2. CareSource will cover scheduled inpatient or outpatient surgeries approved and/or pre-certified pursuant to OAC 5160-2-40. Surgical procedures also include follow-up care as appropriate.
   3. CareSource will cover organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC 5160-2-65.

III. CareSource will provide the following services to members regardless of prior authorization or pre-certification or if the treating provider is a participating or non-participating provider:
   A. ongoing chemotherapy or radiation treatment
   B. hospital treatment if the member was released from the hospital 30 calendar days prior ot enrollment
   C. private duty nursing and home care services
   D. durable medical equipment at the same level with the same provider as previously covered until CareSource conducts a medical necessity review and renders an authorization decision pursuant to OAC 5160-26-03.1

IV. Transitions Between CareSource and OhioRISE
   Upon notification that a member will be enrolled with or disenrolled from the OhioRISE for behavioral health services, CareSource will assign a care coordination staff person to coordinate transition, including retaining care coordination for at least 90 calendar days following disenrollment and including the following:
   A. Coordination of Inpatient Hospital Prior Authorization (PA)
      1. Individuals under the age of 21 not yet enrolled in OhioRISE with a PA for inpatient psychiatric or substance use disorder (SUD) admission
         a. Within 1 business day of receipt, CareSource will inform the hospital of denial of the PA due to payment responsibility by OhioRISE. CareSource will provide guidance regarding how to submit the PA to OhioRISE and will explain the importance of entering the admission into the CANS IT system. OhioRISE will perform outreach to coordinate the transition of care through the inpatient stay.

b. Once the hospital has been notified of the above, CareSource will deny the PA and issue a Notice of Action (NOA) indicating responsibility of OhioRise to pay for the service.
c. CareSource will contact OhioRISE Transition of Care Coordinator, provide notice of the PA request and contact information for the hospital, ensure entry of the psychiatric or SUD admission in the CANS IT system, and share any documentation related to the request by the hospital.

2. If the primary diagnosis on the PA request initially indicated that OhioRISE authorized the service and would be responsible for the claim, and later changes in care delivery result in the APR-DRG becoming the responsibility of CareSource per the OhioRISE Mixed Services Protocol, CareSource will accept the PA approval issued and will not require any additional PA request from the provider.

B. Continuation of Behavioral Heath (BH) Services for OhioRise Members Transitioning to CareSource
CareSource will allow a member who was receiving BH services from OhioRISE to continue to receive those BH services with out-of-network providers if the provider is an ODM-enrolled provider, even if the services were prior authorized by OhioRISE for at least 45 calendar days from the date of the member's transition out of OhioRISE or until CareSource can transition services to a network provider. CareSource will
1. work with the provider to add the provider to the CareSource network
2. implement a single case agreement with the provider, if necessary
3. assist the member in finding and transitioning service delivery to another provider without a disruption in services

V. Documentation of Transition of Services
CareSource will maintain documentation of all member and provider contacts and document the transition of services as follows:
A. CareSource will seek confirmation from non-participating provider(s) that the provider agrees to provide the service and accepts the Medicaid Fee For Service rate as payment or a negotiated rate.
1. If the provider agrees, CareSource will distribute materials to the out-of-network provider as specified by ODM.
2. If the provider does not agree, CareSource will notify the member of availability to assist with locating another provider as expeditiously as the member's health condition warrants.

B. If the service will provided by a participating provider, CareSource will notify the network provider and the member to confirm CareSource's responsibility to cover the service.

VI. 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.

D. Conditions of Coverage
N/A

E. Related Policies/Rules
I. *CareSource Ohio Medicaid Provider Manual*, CareSource; 2023.
II. Medical Necessity Determinations
III. *The Ohio Dept. of Medicaid Provider Agreement for Managed Care Organization*, Ohio Dept. of Medicaid. Revised January 1, 2024.

F. Review/Revision History

	DATES	ACTION
Date Issued	09/04/2019	
Date Revised	05/26/2021 06/01/2022 02/14/2024	 Revision to PA requirements. Expanded pregnancy to 90 days. Added PA not required for family planning services. Annual review; rewrote policy according to 2024 ODM Provider Agreement for MCO; updated References. Approved at Committee.
Date Effective	06/01/2024	
Date Archived		

G. References
1. Inpatient Hospital Reimbursement. OHIO ADMIN. CODE 5160-2-65 (2024).
2. Managed Care, 42 C.F.R. §§ 438 (2024).
3. Managed Care Programs, OHIO ADMIN. CODE 5160-26-01 to 13 (2023).
4. Medicaid: Definitions, OHIO ADMIN. CODE 5160:1-1-01 (2023).
5. Medicaid Medical Necessity: Definitions and Principles, OHIO ADMIN. CODE 5160-1-01 (2022).
6. Psychiatric Pre-Certification Review, OHIO ADMIN. CODE 5160-2-40 (2022).
7. Special Rules for Ambulance Services, Emergency and Urgently Needed Services, and Maintenance and Post-Stabilization Care Services, 42 C.F.R. § 422.113 (2024).
8. State Plans for Medical Assistance, 42. U.S.C. § 1396a(e)(5) (2024).

Approved by Ohio Dept. of Medicaid (ODM) February 29, 2024