Transition of Care Policy for CHIP and Healthy Kids Full-Pay

Eligibility

This transition of care policy does not apply to Medicaid enrollees. Children's Medical Services (CMS) Plan enrollees, MediKids enrollees, and Florida Healthy Kids enrollees are eligible for the corresponding section(s) under this policy as follows:

Part A: Title XXI enrollees experiencing a change in enrollment between MediKids coverage, CMS Plan coverage, or Florida Healthy Kids coverage without a break in coverage or loss of Title XXI status and any enrollee experiencing a change in enrollment from MediKids coverage or CMS Plan coverage to Florida Healthy Kids coverage without a break in coverage.

Part B: Enrollees moving enrollment from one Florida Healthy Kids plan to another Florida Healthy Kids plan without a break in coverage.

Part C: Title XXI enrollees moving enrollment from one MediKids plan to another MediKids plan without a break in coverage or loss of Title XXI status.

Transition of Care

Part A

The transitioning enrollee's new managed care organization (MCO) will provide services as described in Part B when the continued services are covered benefits under the new program.

In the event a transitioning enrollee requires continuation of services covered by the enrollee's previous program that are not covered under the new program and the absence of continued services would result in serious detriment to the enrollee's health or place the enrollee at risk of hospitalization or institutionalization, the enrollee's MCO under the new program will cover such services in the same manner as described in Part B. The enrollee's new MCO is responsible for making coverage determinations.

In the event an enrollee transitions from one program to another and changes MCOs within the continuation of care period, the continuation of care period for any services related to the previous coverage will be based upon the enrollee's enrollment date in the new program. The continuation of care period for such services does not restart when the enrollee changes MCOs within a program.

Part B

Timeframes

Standard continuation of care period: 60 days

Exceptions to standard continuation of care period:

- Maternity care, including prenatal and postpartum care
    - Through completion of postpartum care (6 weeks after birth)
- Transplant services
    - Through first year post-transplant
- Radiation and/or chemotherapy
    - Through current round of treatment
- Orthodontia
    - Current provider covered through 60-day period
    - Services must be continued without interruption after the 60-day period until completion
        - A network orthodontist may be required as long as services are not interrupted.
- Controlled substance prescriptions
    - If a new prescription is required by Florida law, the plan will assist the enrollee in scheduling an appointment with the original prescribing provider, or a new provider if needed, to ensure the enrollee may obtain a new prescription without a medication gap.

Benefits

- New MCO covers prior authorized ongoing course of treatment with any provider, including:
    - Allow enrollees to continue to see same provider(s) even if not in network.
    - When an appointment is scheduled prior to the continuation of care period for a time after the continuation of care period, MCO should ensure the enrollee's PCP or other appropriate physician reviews the treatment plan within the continuity of care period to ensure that needed services continue to be authorized. MCO may require enrollee to see network provider.
    - Continuation of coverage period applies only to benefits specified under the Healthy Kids subsidized program. Additional benefits provided at the option of the MCO are not eligible for continuation of coverage.
    - MCO must continue to provide prescription benefits, including refills, but may require enrollee to use a participating pharmacy.

Medical Records

The MCOs are responsible for coordinating transfer of medical records and necessary utilization information between themselves and assisting providers with obtaining necessary medical records, in accordance with all applicable laws.

Claims payment

The new MCO must honor any written documentation of prior authorization of ongoing covered services during the continuity of care period, including:

- Prior existing orders
- Provider appointments
- Prescriptions
- Prior authorizations
- Treatment plans or plans of care

The new MCO may require the following of the network or out-of-network provider in order to receive payment:

- Submit written documentation of prior authorization
- Follow MCO's established process for submitting claims

The new MCO cannot require additional authorization for any ongoing course of treatment or delay service authorization if contacted by provider for prior authorization if written documentation is not available in a timely manner, but the MCO may require the written documentation before paying the claim.

The new MCO must provide out-of-network providers with information the provider needs to be able to successfully submit a claim for payment.

The new MCO is responsible for costs of services regardless of whether provider is participating or not.

- Payment to out-of-network providers at same rate the provider received for services rendered to enrollees in last 30 days is encouraged, but not required.
- MCO may engage in any cost control mechanisms available, including negotiations, when paying out-of-network provider claims so long as the enrollee is not financially impacted.

The new MCO may encourage enrollees and providers to notify the MCO of needed continuation of coverage but may not deny payment because of lack of prior notification.

Part C

MediKids follows the Medicaid continuity of care policy.