ADMINISTRATIVE POLICY STATEMENT
D-SNP

Policy Name & Number	Date Effective
Continuity of Care-DSNP-AD-1385	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.

This policy applies to the following Marketplace(s):	
☒ **Georgia**	☒ **Ohio**

Table of Contents

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 or ordered course of 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.
- **Network Health Partner** - A health partner in a contractual arrangement with CareSource or is being used by CareSource, or another organization with an agreement to provide certain covered services or administration functions, including non-network health partners used for other services or products not covered by the contractual arrangement with CareSource as covered services.
- **Network Provider** - Any provider, group of providers, or entity that has a network provider contract with CareSource to order, refer, or render covered services or other administrative functions as a result of said contract.
- **Non-Contracting Provider** - Any provider who does not have a contract with CareSource but delivers health care services to members.
- **Primary Care Provider (PCP)** - An individual physician (MD, DO) or group practice, an advanced practice registered nurse (APRN) or group practice within an acceptable specialty, or a physician assistant contracted with CareSource to provide primary care services for members, including 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 that is 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.

- **Terminal Illness** - Medical prognosis of 6 months or less of life.

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, CareSource plan members may qualify for COC coverage in the following circumstances:

1. The member chooses to receive care from a non-network provider. Prior authorization must be obtained. If the existing physician or nurse practitioner is not in the CareSource network, coverage will be extended as follows:
   a. eligibility up to 90 days calendar days after the coverage effective date, if
      01. the physician or nurse practitioner does not participate in another Medicare plan for which a member is eligible
      02. the physician or nurse practitioner is providing an active course of treatment or is a member's primary care physician (PCP)
   b. pregnant at enrollment and through the postpartum period
   c. until death if diagnosed with a terminal illness
2. The member is or will be receiving services for which a prior authorization was received from another plan or payer. If the member enrolls in CareSource after starting a course of treatment, there is no requirement for a prior authorization, effective for the shorter of the 90-day period or the end of the active course of treatment.

B. Terminations of contractual relationships between CareSource and providers and/or facilities will result in changes to the provider network status. CareSource will review COC benefits when the following events occur:

1. A contractual relationship with a CareSource health partner is terminated for reasons other than quality-of-care issues or fraud. CareSource may authorize continuing coverage for up to 90 days after a provider/facility leaves the CareSource network and will assist members with locating an in-network provider.
2. For members undergoing an active course of treatment for illness or injury, CareSource may authorize continuing coverage from the date the health partner left the CareSource network through the acute phase of sickness or up to 90 calendar days, whichever is shorter.

II. CareSource will make good faith efforts to notify members in writing of any PCP or behavioral health provider contract termination within 45 days prior to termination from the CareSource network. For any other specialty groups, CareSource will make contact within 30 days. Members are also encouraged to notify CareSource of any COC requests.

III. Other Services
Some COC services will be subject to medical necessity review. Additional services include the following (not an all-inclusive list):
A. Institutional clinic settings will be covered through discharge, including discharge planning and coordination of supplies and services needed following discharge.
B. Medical hospitalization or post emergency care for members will be covered.
C. 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.

E. Conditions of Coverage

I. Authorization for COC services will be given for health partners meeting the following conditions:
A. accepts payment from CareSource at rates paid to network health partners of the same specialty or sub-specialty as payment in full and will not charge the member more than what would have been paid if the health partner was in the CareSource network
B. complies with CareSource' quality assurance standards and policies and procedures, including, but not limited to, procedures regarding referrals, obtaining prior authorization, and providing covered services pursuant to a treatment
C. provides CareSource with necessary medical information related to care provided

II. COC requirements include a process for inclusion of enrollee data from the electronic exchange of information with managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans. Data should be included for the previous 5 years.

F. Related Policies/Rules

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. Continued Services to Enrollees, 42 C.F.R. § 438.62 (2023).
2. *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
3. Coordination and Continuity of Care, 42 C.F.R.§ 438.208 (2023).

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

4. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
5. Managed Care, 42 C.F.R. § 438 (2023).
6. Medicare Advantage Program, 42 C.F.R. § 422 (2023).
7. *Medicare Managed Care Manual, Chapters 11 and 17*. Centers for Medicare and Medicaid Services. Accessed October 3, 2023. www.cms.gov
8. Services: General Provisions, 42 C.F.R. § 440 (2023).
9. Special Rules for Ambulance Services, Emergency and Urgently Needed Services, and Maintenance and Post-Stabilization Care Services, 42 C.F.R. § 422.113 (2023).