CareSource

ADMINISTRATIVE POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Continuity of Care-MP-AD-1258	01/01/2024-01/31/2025
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.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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. COC promotes safety and effective healthcare to transitioning members.

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 non-elective 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.
- **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.
- **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.
- **Covered Services** - Health care services that are (1) covered by a specific benefit provision; (2) not excluded; and (3) determined to be medically necessary per medical policies and nationally recognized guidelines determined to be all the following:
  - provided for the purpose of preventing, diagnosing, or treating a sickness, injury, behavioral health disorder, substance use disorder, or symptoms
  - consistent with nationally recognized scientific evidence and prevailing medical standards and clinical guidelines
  - not provided for the convenience of members, providers, or any other person
- **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 life expectancy that is 6 months or less.
- **Terminated** - With respect to a contract, the expiration or nonrenewal of a contract excluding termination due to failure to meet applicable quality standards or fraud.

D. Policy

I. Eligibility for Continuity of Care
CareSource will review COC requests submitted by members or on behalf of members.

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 30 days calendar days after the coverage effective date, if
01. the physician or nurse practitioner does not participate in another plan for which a member is eligible through the Marketplace
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.

B. Terminations of contractual relationships between CareSource and providers and/or facilities will result in changes to provider network status. Termination requests will be reviewed when **any** of the following qualifying events occur:
1. A contractual relationship with a CareSource health partner is terminated (see 'terminated' definition above).
2. Benefits provided with respect to a certain provider or facility are terminated because of a change in the terms of participation in the plan or coverage.
3. A contract between a plan and health insurer offering health coverage in connection with the plan is terminated, resulting in a loss of benefits provided under the plan with respect to providers and facilities.

II. Notification by CareSource
Once CareSource is notified that a provider or facility is leaving the network or there is a change in the provider's facility affiliation, members will be notified in writing within 30 days after the provider or facility leaves the network or of the change in provider affiliation.

III. Continuing care members will be provided an opportunity to notify CareSource of the need for transitional care.

IV. The member can elect to continue to have benefits provided under the previous plan or coverage had termination not occurred with respect to the course of treatment furnished by the provider or facility relating to the member's status as a continuing care patient during the period beginning on the date on which the notice was provided and ending on the earlier of the following:
   A. the 90-day period beginning the date notice is provided
   B. the date on which the member is no longer a continuing care patient with the provider or facility

V. Health care services rendered by a provider who is disenrolled from the network or a non-network provider as described in this policy will only be covered when the health care services would otherwise be covered services if provided by a network provider, and the provider agrees to comply with the following:
   A. accept payment from CareSource at the rates CareSource pays to network providers of the same specialty or sub-specialty
   B. accept such payment as payment in full and not charge the member any more than the member would have paid if the provider was a network provider
   C. comply with CareSource's quality assurance standards
   D. provide CareSource with necessary medical information related to the care provided
   E. comply with policies and procedures, including, but not limited to, procedures regarding referrals, obtaining prior authorization, and providing covered services pursuant to a treatment approved by CareSource

E. State Specific Information
NA

F. Conditions of Coverage
NA

G. Related Policies/Rules
Medical Necessity Determinations

H. Review/Revision History

DATE		ACTION
Date Issued	11/09/2022	New policy
Date Revised	10/11/2023	Annual review. Revised definitions/policy section for compliance to No Surprises Act and 2024 EOCs. Approved at Committee.
Date Effective	01/01/2024	
Date Archived	01/31/2025	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

I. References
1. *Continuity and Coordination of Care: A Practice Brief to Support Implementation of*

The WHO Framework on Integrated People-Centred Health Services. World Health Organization; 2018. Accessed September 7, 2023. www.who.intContinuation of Care Provisions, IND. CODE § 27-13-36-6 (2023).
2. Continuity of Care, 42 U.S.C. §300gg–113 (2023).
3. *Georgia Evidence of Coverage*. CareSource; 2024. Accessed September 7, 2023. www.caresource.com
4. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
5. *Indiana Evidence of Coverage*. CareSource; 2024. Accessed September 7, 2023. www.caresource.com
6. *Kentucky Evidence of Coverage*. CareSource; 2024. Accessed September 7, 2023. www.caresource.com
7. *Ohio Evidence of Coverage*. CareSource; 2024. Accessed September 7, 2023. www.caresource.com
8. Standards for Certification, GA. CODE ANN. § 33-20A-5 (2023).
9. Standards for Provider Participation, KY. REV. STAT. § 304.17A-525 (1998).
10. *The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements*. Centers for Medicare and Medicaid Services; 2021. Accessed September 7, 2023. www.cms.gov
11. *West Virginia Evidence of Coverage*. CareSource; 2024. Accessed September 7, 2023. www.caresource.com