ADMINISTRATIVE POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Continuity of Care-MP-AD-1258	GA, IN, KY, WV: 05/01/2023-12/31/2023 OH: 06/01/2023-12/31/2023
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.

☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Continuity of Care

B. Background

Continuity of Care (COC) provides newly enrolled members who meet specific criteria continued care with a former or non-participating provider (including acute hospitals) during transition to a participating provider. COC also may apply to existing members who are impacted when a participating provider, including practitioners and general acute care hospitals, terminates an agreement with CareSource. In order to ensure that care is not disrupted or interrupted, the COC process becomes a bridge of coverage, allowing members to transition from their old plan to CareSource or from a terminated provider to a CareSource participating provider.

The American Academy of Family Physicians (AAFP) defines continuity of care as the process by which the patient and his or her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high-quality and cost-effective medical care. A recent study revealed that COC improves physician/patient relationships, medical outcomes and also reduces healthcare costs.

C. Definitions

- **Acute Condition** - A medical or behavioral condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and has a limited duration.
- **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, or requires ongoing treatment to maintain remission or prevent deterioration.
- **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.
- **Non-Participating Provider** - A provider who has not entered into a contractual arrangement with CareSource. Also known as an out-of-network provider.
- **Postpartum Period** - A span of at least sixty days, beginning on the date a woman's pregnancy ends and ending on the last day of the month in which the sixtieth day falls.
- **Primary Care Provider (PCP)** - A network physician, network physician group, advanced practice nurse or advanced practice nurse group trained in family medicine (general practice), internal medicine, or pediatrics who is responsible for providing and/or coordinating all covered services for the member benefits.
- **Terminal Illness** - An illness with a life expectancy of 6 months or less if the illness runs its normal course.
- **Transition of Care** - A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.

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D. Policy

I. CareSource expects members to seek health care services from network providers. However when appropriate, CareSource will manage continuity of care requests for members by coordinating care across the CareSource network to ensure that the member's care is not disrupted or interrupted.
   A. COC concerns may arise when a non-network provider is treating a member when the member first enrolls in CareSource.
   B. COC issues may arise when:
      1. A network provider is no longer a provider within the CareSource network; or
      2. When the member is or will be receiving services for which a prior authorization was received from another plan or payer.

II. If circumstances fall within the provisions identified below, the member will be eligible for continuity of care from a non-network provider for the identified time period.
   A. CareSource will continue to pay for covered services received from a PCP for 30 calendar days after the date the PCP leaves the network, unless the PCP was terminated from the CareSource network for reasons related to fraud or quality of care.
   B. If the member is undergoing an active course of treatment with the PCP or a provider seen on a regular basis and the PCP or provider who the member sees on a regular basis was removed from the network without cause, then CareSource may authorize continuing coverage with that PCP or provider.
      1. Such continuing coverage shall be for a period of up to 90 days, either:
         a. From the date that the PCP or provider left the network; or
         b. Until the treatment is complete, whichever is shorter.
      2. CareSource will pay for such benefits as though the PCP or provider is in-network and will calculate any copayments, coinsurance, or deductibles at the in-network rates if:
         a. The member has successfully transitioned to a network provider, met or exceeded the benefit limits under the plan; or
         b. The treatment is not medically necessary, in which case CareSource may not authorize continuing coverage with that PCP or provider the member has seen on a regular basis. The PCP or provider should contact the Medical Management Department to obtain prior authorization.
   C. If the member is a woman in the first, second or third trimester of pregnancy and the network provider being seen in connection with the pregnancy leaves the network (for reasons other than fraud or quality of care), the member may, with CareSource prior authorization, continue to receive covered services from that provider through the delivery of the child, immediate postpartum care, and examination within the first 6 weeks following delivery. The provider should contact the Medical Management Department to obtain prior authorization.
   D. If the member has a terminal illness, and the provider being seen in connection with the terminal illness is no longer participating in CareSource (for reasons other than fraud or quality of care), the member may, with prior authorization, continue to receive covered services provided by that provider until health care

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services are no longer needed. The provider should contact the Medical Management Department to obtain prior authorization.

III. Continuity of Care for Newly Covered Persons

For a new covered member on CareSource, CareSource will provide coverage for Covered Services provided by the existing physician or nurse practitioner, if he or she is a non-network provider, as follows:

A. For up to 30 days after the coverage effective date if:
   1. The physician or nurse practitioner does not participate in another Marketplace Qualified Health Plan for which the member is eligible through the Marketplace; or
   2. The physician or nurse practitioner is providing with an active course of treatment or is the member's PCP
B. Through the first postpartum visit, if the member is a new covered person in the first, second or third trimester of pregnancy when coverage becomes effective.
C. Until death, if the member is a new covered person with a terminal illness.
D. Prior authorization must be obtained before continuing care with a non-network provider.

IV. 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:

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; and
E. Comply with CareSource 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. Conditions of Coverage

NA

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	11/09/2022	New policy
Date Revised		

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

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Date Effective	GA, IN, KY, WV: 05/01/2023 OH: 06/01/2023	
Date Archived	GA, IN, KY, WV: 12/31/2023 OH: 12/31/2023	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.

H. References

1. American Academy of Family Physicians. Continuity of care, definition of [Internet] Leawood (KS): American Academy of Family Physicians; 2015.
2. CareSource. Evidence of Coverage: Georgia. Retrieved December 15, 2022 from www.caresource.com.
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4. CareSource. Evidence of Coverage: Kentucky. Retrieved December15, 2022 from www.caresource.com.
5. CareSource. Evidence of Coverage: Ohio. Retrieved December15, 2022 from www.caresource.com.
6. CareSource. Evidence of Coverage: West Virginia. Retrieved December 15, 2022 from www.caresource.com.
7. Centers for Medicare & Medicaid Services. Ending surprise medical bills. (December 5, 2022). Retrieved December 15, 2022 from www.cms.gov.
8. Kim JH, Park EC, Kim TH, Lee Y. Hospital charges and continuity of care for outpatients with hypertension in South Korea: a nationwide population-based cohort study from 2002 to 2013. Korean J Fam Med. 2017;38:242–248.

I. State-Specific Information

A. Georgia
   1. Effective: 05/01/2023

B. Indiana
   1. Effective: 05/01/2023

C. Kentucky
   1. Effective: 05/01/2023

D. Ohio
   1. Effective: 06/01/2023

E. West Virginia
   1. Effective: 05/01/2023

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