ADMINISTRATIVE POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Continuity of Care-WI MP-AD-1477	12/01/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract 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.

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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 the member is in a qualifying course of treatment with an approved authorization to do so from the plan. 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** – Services or supplies that are (1) medically necessary; (2) described as a covered health service in the certificate of coverage and in the schedule of benefits; (3) not otherwise excluded in the certificate of coverage; and (4) provided to prevent, diagnose, or treat a sickness, injury, mental illness, substance use disorder services or associated symptoms.
- **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

The provisions outlined below do not apply for providers who are no longer practicing in the service area or who were terminated from the network for cause (eg, failure to meet credentialing standards, quality of care issues, fraud). CareSource will review COC requests submitted by members or on behalf of members as follows:

A. Newly enrolled, CareSource plan members may qualify for COC coverage as follows:
   1. Members in the 3rd trimester of pregnancy at the time of enrollment may receive obstetric care through the completion of postpartum care.
   2. Members in the 1st or 2nd trimester at enrollment must transition pregnancy care to an in-network provider.

B. Terminations of contractual relationships between CareSource and providers and/or facilities will result in changes to provider network status. Requests for COC in situations where providers who were part of the CareSource network at the time a member enrolled but are now leaving the network without cause will be reviewed according to the following:
   1. Members may continue to access a primary care provider at the in-network level of benefits through the end of the policy year.
   2. If a member is undergoing a course of treatment with a provider who is not a primary care provider, the member can continue to access the provider at the in-network level of benefits for up to 90 days, the end of the course of treatment, or the end of the policy year, whichever is shorter.
   3. Pregnant members who are in the 2nd or 3rd trimester of pregnancy may access providers for maternity care at the in-network level of benefits until the completion of postpartum care for the woman and infant.

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 30 days prior to termination or 15 days following the date the provider's termination notice is received by CareSource, whichever is later.

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

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 comply with the following:

A. Accept payment at the rates CareSource pays network providers of the same specialty or sub-specialty or according to the most recent contracted rate.

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 CareSource.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	08/14/2024	New market. Approved at Committee.
Date Revised		
Date Effective	12/01/2024	
Date Archived		

H. 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 August 5, 2024. www.who.int
2. Continuity of Care, 42 U.S.C. § 300gg–113 (2023).
3. Continuity of Care, WIS. ADMIN. CODE § 9.35 (2006).
4. Continuity of Care, WIS. STAT. § 609.24 (2001).
5. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
6. *The No Surprises Act's Continuity of Care, Provider Directory, and Public Disclosure Requirements*. Centers for Medicare and Medicaid Services; 2021. Accessed August 5, 2024. www.cms.gov

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