



ADMINISTRATIVE POLICY STATEMENT

Georgia Medicaid

Policy Name & Number	Date Effective
Continuity of Care-GA MCD-AD-0749	10/01/2025
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.

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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/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 and recognizes the importance of established relationships between members and providers.

CareSource employs a system of care approach to care coordination and COC. Care coordination includes case management, disease management, transition of care and discharge planning. COC policies are designed to accommodate the specific cultural and linguistic needs of the members and include, at a minimum, all elements as defined by the contract with the State of Georgia. CareSource's approach to COC ensures a set of member-centered, goal-oriented, culturally relevant and logical steps ensuring that members receive needed services in a supportive, effective, efficient, timely and cost-effective manner.

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.
- **Care Coordination** – The process of actively linking a member, in a timely manner, to providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified.
- **Case Management (CM)** – A person-centric, collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's health needs through communication and available resources to promote quality cost-effective outcomes as a means for achieving member wellness and autonomy through advocacy, communication, education and identification of services and resources with interventions undertaken to help members receive appropriate care. CM is voluntary and intensely focused on any member disease or condition.
- **Care Management Organization (CMO)** – An entity organized for the purpose of providing health care with a health maintenance organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with providers.

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

- **Chronic Condition** – Any ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities, with an expected duration of at least 12 months resulting in functional limitations, reliance on compensatory mechanisms (eg, medications, special diet, assistive device) and service use or need beyond routine care.
- **Health Check Program** – The Early and Periodic Screening components of the EPSDT benefit are covered under this program pursuant to Title XIX of the Social Security Act.
- **Non-Participating Provider** – A provider without a contractual arrangement with CareSource, also known as an out-of-network provider.
- **Participating (In-Network) Provider** – A healthcare provider or other organization with a contractual arrangement or agreement with CareSource to provide certain covered services or administration functions.
- **Primary Care Provider (PCP)** – A licensed health care practitioner, usually a doctor, nurse practitioner (NP), or physician assistant (PA) who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to members. A PCP shall include general/family practitioners, pediatricians, internists, OB/GYNs, PAs, and NPs with a role that includes
 - providing preventive care and teaching healthy lifestyle choices
 - identifying and treat common medical conditions
 - assessing the urgency of medical problems and directing members to the best place for care making referrals to medical specialists when necessary
- **Specialized Medical Care** – Significant medical conditions that require ongoing care of specialist appointments.
- **Terminal illness** – An illness with a life expectancy of 6 months or less if the illness runs a normal course.
- **Transition of Care** – The movement of patients between health care practitioners and/or settings as a condition or care needs change during the course of a chronic or acute illness.

D. Policy

- I. Services may be subject to medical necessity review.
- II. CareSource will review COC requests submitted by members or on behalf of members when the following occurs:
 - A. Clinical review may occur. CareSource is not obligated to cover services beyond 30 CDs even if the prior authorization (PA) was for a period greater than 30 CDs unless necessary to prevent serious detriment to a member's health or reduce the risk of hospitalization or institutionalization. Upon transferring to CareSource, newly enrolled members who have established relationships with providers will be allowed care for 30 calendar days (CDs) for the following:
 1. PA received from other payers for services

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2. care from a non-participating health partner treating the member prior to enrollment
 3. continuing access by the member to the member's PCP
 4. ongoing outpatient treatment or for members receiving medication covered by another payer
- B. A health partner or provider is terminated from the CareSource network and that termination was not related to fraud or a quality of care issue, 90 calendar days of service will be allowed for the following members while the non-participating health partner transfers care to a participating health partner:
1. members receiving an active course of treatment for a chronic illness
 2. members receiving inpatient services
 3. members with a terminal illness
- III. Transition of Members Between CMOs and Fee-For-Service (FFS) Medicaid
- A. CareSource will coordinate the transfer of information, including historical utilization data, when members transition to another payer. CareSource will identify and facilitate transitions for members who require additional, distinctive assistance or are hospitalized and cooperate with other payers regarding the course of ongoing care with a specialist or other provider and will include discharge planning, as appropriate. Priority will be given to members with medical conditions/circumstances, including (not all-inclusive)
1. members currently hospitalized
 2. pregnant women at high risk and in the third trimester or within 30 CDs of the anticipated delivery date
 3. major organ or tissue transplantation services in process or authorized
 4. chronic illness that placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing or other facilities
 5. members in treatment (eg, chemotherapy, radiation therapy, dialysis)
 6. members with ongoing needs (eg, specialized durable medical equipment)
 7. current home health services
 8. medically necessary transportation on a scheduled basis
 9. prescription medications requiring PAs
- B. When relinquishing members, CareSource will cooperate with the receiving CMO, FFS Medicaid or private insurance regarding ongoing care with a specialist or other provider. COC will be facilitated for all members during changes or transitions. Members with special circumstances may require additional or distinctive assistance. Special circumstances include special health care needs and
1. pregnancy, especially women at high risk and in third trimester or within 30 CDs of an anticipated delivery date
 2. major organ or tissue transplantation services in process or authorized
 3. chronic illness, which places a member in a high-risk category and/or results in hospitalization or placement in nursing or other facilities
 4. significant medical conditions, (eg, diabetes, hypertension, pain control, orthopedics) requiring ongoing care of specialist appointments

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5. members in treatment, such as
 - a. chemotherapy, and/or radiation therapy
 - b. dialysis
6. members with ongoing needs, including
 - a. durable medical equipment, including ventilators and other respiratory assistance equipment
 - b. home health services
 - c. medically necessary transportation on a scheduled basis
 - d. prescription medications

IV. Coverage Responsibility

A. Long-Term Care Coverage Responsibility

1. Members enrolled in CareSource and receiving services in a long-term care facility (ie, nursing homes, skilled nursing facilities, psychiatric residential treatment facility, other facilities providing long-term non-acute care) will remain the responsibility of CareSource until disenrolled from CareSource by DCH. At disenrollment, financial responsibility for services transitions to the new CMO or FFS Medicaid.
2. Members in ongoing, nonacute treatment in an inpatient facility that has been covered by DCH or another CMO prior to a new CMO effective date will be covered by the new CMO for at least 30 CDs to allow time for clinical review, and if necessary, transition of care. The CMO will not be obligated to cover services beyond 30 CDs, even if the DCH authorization was for a period greater than 30 CDs.

B. Inpatient Acute Coverage Responsibility

1. Members enrolled in a CMO will remain the responsibility of that CMO until discharged from the facility, even if the member changes to a different CMO or becomes eligible for coverage under FFS Medicaid during the stay.
2. Members placed in foster care during the stay will be disenrolled from the CMO and enrolled in the Georgia Families 360° Program on the date the member's 834 file is transferred to the Georgia Families 360° CMO.
3. The CMO is not required to cover services with no Medicaid eligibility. If the member loses eligibility during the stay, payment will continue only until the last day of eligibility.
4. A Planning for Healthy Babies (P4HB) participants will remain the responsibility of the original CMO until discharged, despite changes to a different CMO or becoming eligible for other coverage. The CMO is not required to cover Demonstration-related services if there is no Demonstration eligibility. The CMO is only responsible for payment until the last day of eligibility.
5. Inpatient care for newborns born on or after a mother's effective date will be the responsibility of the mother's assigned CMO.
6. CareSource will remain responsible for members becoming eligible and enrolled in any retroactive (eg, Social Security) coverage after the date of an inpatient hospitalization until discharged. Applicable members will remain the responsibility of CareSource for all covered services, even if the start date for

SSI eligibility is made retroactive to a date prior to the inpatient acute hospitalization.

C. Inpatient Newborn Infants

1. CareSource will pay for health care services provided to a newborn infant born to a mother currently enrolled with CareSource until the newborn is discharged from all inpatient care to a home environment subject to approval by the federal Centers for Medicare and Medicaid Services. For a newborn infant with a mother enrolled in a Medicaid program receiving Medicaid benefits directly from DCH, DCH will pay for health care services provided to the newborn until the newborn is discharged from all inpatient care to a home environment.
2. In the event a newborn is disenrolled from CareSource and re-enrolled into the Medicaid FFS program conducted directly by DCH, CareSource will ensure the coordination of care for that child until appropriately discharged from the hospital and placed in an appropriate care setting.

E. Conditions of Coverage

CareSource will assist providers in obtaining medical records for members.

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	09/18/2019	New policy. Approved at Committee.
Date Revised	04/01/2023	Annual review.
	02/14/2024	Annual review. Revised definitions (GA contract language). Approved at Committee.
	07/30/2025	Annual review. Revised sections according to contract amendment. Added D.IV.C. Updated references. Approved at Committee.
Date Effective	10/01/2025	
Date Archived		

H. References

1. Coordination and Continuity of Care, 42 C.F.R. § 438.208 (2023).
2. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
3. Medicaid Managed Care Organizations, GA. CODE ANN. §§ 33-21A (2023).
4. *State of Georgia Amended and Restated Contract between The Georgia Dept of Community Health and CareSource Georgia Co. for Provision of Services to Georgia Families*. Dept of Community Health; 2025. Accessed June 24, 2025.

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