

Administrative Policy Statement INDIANA MEDICAID

	Policy Number	Date Effective
Continuity of Care	AD-0743	4/1/2020 - 12/21/2022
Policy Type		
Medical	ADMINISTRATIVE	Pharmacy
		Reimbursement

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) 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 CSMG Co. and its affiliates (including CareSource) 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.

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A. Subject

Continuity of Care

B. Background

Continuity of Care (COC) provides newly enrolled members meeting 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 (practitioners and general acute care hospitals) terminates their agreement with CareSource. In order to ensure 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 defines Continuity of Care as “the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high-quality, cost-effective medical care”. A recent study revealed that COC improves physician-patient relationships, medical outcomes and also reduces healthcare costs.

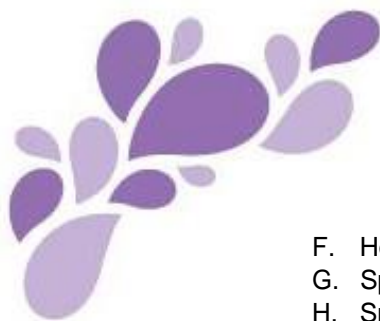
C. Definitions

- **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 (NCQA)
- **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 that 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 or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration
- **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 that are responsible for providing and/or coordinating all covered services for network benefits
- **Participating Provider:** A provider who has entered into a contractual arrangement with CareSource, or another organization that has an agreement with CareSource to provide certain covered services or certain administration functions for the network associated with the Evidence of Coverage (EOC). A network provider may also be a non-network provider for other services or products that are not covered by the contractual arrangement with CareSource as covered services
- **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:** Also known as the puerperium, begins with the delivery of the baby and placenta and largely is considered complete six to eight weeks after delivery when the organ systems have generally returned to the pre-pregnancy state
- **Terminal Illness:** An illness with a life expectancy of six (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



D. Policy

- I. CareSource supports Continuity of Care (COC) to ensure consistent healthcare services are delivered through proper coordination combined with information sharing among providers to enhance a patient focused approach. CareSource will honor prior authorizations that were approved by the member's original CMO for at least thirty (30) days during transition to CareSource. This includes existing and uncompleted care treatment plans and scheduled services with non-participating providers. COC services may be subject to a medical necessity review. Requests will be accepted from a member or a provider on behalf of a member.
- II. COC services will be provided when **ONE** of the following occurs:
 - A. The health partner is terminated from the CareSource network and that termination was not related to a fraud or quality of care issue;
 - B. A newly enrolled member requesting continuation of care from the non-participating health partner who was treating them prior to their enrollment; or
 - C. When a newly enrolled member is or will be receiving services for which a prior authorization was received from another payer.
- III. CareSource ensures that prior authorization requirements are not applied to the following:
 - A. Emergency services
 - B. Urgent Care
 - C. Crisis stabilization for behavioral health care
 - D. Renal Dialysis Services
 - E. HIV and Hepatitis C treatment
 - F. Prescription Drugs
 1. Members will receive coverage for the first ninety (90) days **OR** until the provider submits a PA request and a medical necessity review is completed, whichever is completed first.
 2. Any dispensation after ninety (90) days requires provider submission of a PA request.
 3. Members have the option of using an alternative medication without a PA when applicable.
- IV. To coordinate care and facilitate transition, COC services will be provided for **thirty (30)** days to a participating or non-participating provider and may be subject to a medical necessity review, including the following services:
 - A. Medically necessary transportation on a scheduled basis.
 - B. Inpatient and Outpatient Behavioral Health Care for thirty (30) days or until the existing PA is no longer effective, whichever comes first.
 1. Members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge.
 01. These services must be provided within seven (7) days from the date of discharge.
 - C. Inpatient Substance Abuse Treatment
 - D. Physical Therapy, Speech Therapy, Occupational Therapy, Rehabilitation Therapy
 1. Coverage will be provided for the first sixty (60) days or until the benefit limit of 30 visits is reached, whichever is completed first.
 - E. Post Emergency Care
 1. When a member is seen in the ER by a non-participating physician, follow-up care with non-participating physicians will only be covered for thirty (30) days.
 2. Follow-up care beyond thirty (30) days must be with a participating provider.



- F. Home Health Services
 - G. Specialized Medical Care
 - H. Specialized Durable Medical Equipment
- V. Continuity of Care will be provided when an on-going treatment plan is in place, and are subject to a medical necessity review, for the following services:
- A. Medical Hospitalization
 - 1. Members that are already enrolled in a CMO that are hospitalized in an acute inpatient facility will remain the responsibility of the current CMO, even if they change to a different CMO, or they become eligible for coverage under FFS Medicaid during their inpatient stay.
 - 2. Newly enrolled members will receive coverage from the new CMO through discharge, including pre-discharge coordination of care needed following discharge from an institutional clinical setting.
 - 3. Inpatient care for newborns born on or after their mother's effective date will be the responsibility of the mother's assigned CMO.
 - B. Nursing Facility Care for Healthy Indiana Plan Members
 - 1. When an adult member is currently receiving care in a nursing facility on the effective date of enrollment, CareSource will cover the nursing facility care at the same facility 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.
 - C. Pregnancy
 - 1. A continuity of care authorization will be granted for newly enrolled members who are pregnant and the following occurs:
 - a. The member is in the third trimester and has established a relationship with an obstetrician and/or delivery hospital.
 - D. Postpartum Care
 - 1. Mothers will be covered for postpartum care for up to six (6) weeks following delivery with the non-participating provider (or associate within the provider group) who performed the delivery.
 - 2. Newborns delivered by a non-participating provider must be seen for their pediatric care with a participating provider within 30 days of delivery.
 - E. Chronic Dialysis
 - F. Chemotherapy and Radiation Therapy
 - 1. When a member has been placed in a chemotherapy and/or radiation treatment plan and until that treatment plan is completed.
 - G. Major organ or tissue transplantation services which are in process, or have been authorized.
 - H. Surgical care
 - 1. When a member has been placed in a surgical care treatment plan and until that treatment plan is completed.
 - I. Hospice
 - 1. When a Healthy Indiana Plan member has been diagnosed with a terminal illness and life expectancy is six (6) months or less if the illness runs its normal course.
- VI. Continuity of Care Process
- A. If a non-participating provider's services meet medical necessity and the continuity of care policy, the non-participating provider will need to execute a Single Care Agreement (SCA) agreement.



VII. Continuity of care prior authorization requests for services from non-participating specialists will be determined based on the treatment plan received.

- A. When participating providers are not available to provide the needed services after the initial determination, the authorization period may be extended.

E. Conditions of Coverage

F. Related Policies/Rules

G. Review/Revision History

DATES		ACTION
Date Issued	4/1/2020	
Date Revised	TBD	
Date Effective	4/1/2020	
Date Archived	12/21/2022	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. 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.
2. American Academy of Family Physicians. Continuity of care, definition of [Internet] Leawood (KS): American Academy of Family Physicians; 2015. [cited 2017 Sep 7].
3. Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning and CareSource Indiana INC HIP and HHW Contract, September 13, 2019.

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

Independent medical review –N/A

IN-P-0873a

Date Issued 4/1/2020

OMPP Approved 1/7/2020