ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Continuity of Care-IN MCD-AD-0743	02/01/2023
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.

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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

- **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 and/or 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.
- **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 is responsible for providing or coordinating all covered services for network benefits. This includes specialists selected by members with chronic conditions who select a specialist with whom he or she has an on-going relationship to serve as a PCP.
- **Participating Provider** - A healthcare 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.
- **Terminal illness** - An illness with a life expectancy of six (6) months or less if the illness runs it's 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 COC to ensure consistent healthcare services are delivered through proper coordination combined with information sharing among providers to enhance a patient focused approach.
   A. CareSource will honor prior authorizations that were approved by the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP) or by the member's previous Indiana Medicaid Care Management Organization (CMO) for at least **180** calendar days after becoming a CareSource member. 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.
   B. Upon notification that a hospitalized member will be transitioning from CareSource to a new CMO, or to a fee-for-service Medicaid, CareSource will work with the new CMO or fee-for-service Medicaid or private insurance to ensure that coordination of care and appropriate discharge planning occurs.

II. COC services will be provided when **ONE** of the following occurs:
   A. When a newly enrolled member is or will be receiving services for which a prior authorization was received from another payer, services will be provided for 180 days
   B. When a newly enrolled member requests continuation of care from the non-participating health partner who was treating them prior to their enrollment, services will be provider for 180 days; **OR**
   C. When a health partner is terminated from the CareSource network and that termination was not related to a fraud or quality of care issue, services will be provided for 30 days.

III. CareSource ensures that prior authorization requirements are **NOT** applied to the following:
   A. Emergency services
   B. Urgent care services
   C. Crisis stabilization for behavioral health care
   D. Family planning services
   E. Communicable disease services, including STI and HIV testing
   F. Renal dialysis services.

IV. To coordinate care and facilitate transition, COC services will be provided for **180** calendar 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. Physical therapy, speech therapy, occupational therapy and rehabilitation therapy
   C. Inpatient and outpatient behavioral health care
   D. Inpatient substance abuse treatment
   E. Long term care, including: nursing homes, skilled nursing facilities, psychiatric residential treatment facilities and other facilities that provide long term non-acute care. Members enrolled in a CMO that are receiving services will remain the responsibility of the admitting CMO until disenrolled from that CMO. Upon disenrollment responsibility transfers to the new CMO or fee for service Medicaid
   F. Post Emergency Care
      1. When a member is seen in the emergency room by a non-participating physician, follow-up care with a non-participating physician will only be covered for 30 days
      2. Follow-up care beyond 30 days will be subject to a medical necessity review.
   G. Home health services
   H. Specialized medical care. Significant medical conditions that require ongoing care of specialist appointments

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

I. Specialized durable medical equipment including ventilators and other respiratory assistance equipment.

V. Continuity of Care Services will be provided for services when an **on-going treatment** plan is in place for the following services:
   A. Medical hospitalization: members will receive coverage through discharge, including the following:
      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 fee for service 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 Indiana CMO.
   B. Pregnancy
      1. A continuity of care authorization will be granted, from the effective date through the postpartum period, for newly enrolled members who are pregnant and have already begun prenatal care with a non-participating health partner
         a. This includes instances when a non-participating physician providing care through the postpartum period, is part of a non-participating physician group. (01). All physicians within the physicians group will be covered under COC
      2. Members with a history of high-risk pregnancy who wish to see the non-participating health partner that treated them for a previous high risk pregnancy will be approved for coverage from the non-participating provider during their prenatal and postpartum period
      3. Newborns seen in the hospital by a non-participating provider must continue care with a participating provider within 30 days of delivery.
   C. Dialysis
   D. Chemotherapy and radiation therapy when a member has been placed in a chemotherapy and/or radiation treatment plan and until that treatment plan is completed.
   E. Major organ or tissue transplantation services which are in process, or have been authorized.
   F. Surgical care when a member has been placed in a surgical care treatment plan and until that treatment plan is completed.
   G. Hospice when a member has been diagnosed with a terminal illness and life expectancy is 6 months or less, if the illness runs it's normal course.

VI. Continuity of Care Process
   If a non-participating provider's services meet medical necessity and the COC policy, the non-participating provider will need to sign a single case agreement (SCA) document.

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

N/A

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

F. Related Policies/Rules

N/A

G. Review/Revision History

DATES		ACTION
Date Issued	4/1/2020	
Date Revised	8/17/2022	Updated in line with UM P&P. Editorial revisions.
Date Effective	02/01/2023	
Date Archived		

H. References

1. American Academy of Family Physicians. Continuity of care, definition of [Internet] Leawood (KS): American Academy of Family Physicians; 2015. [cited 2017 Sep 7].
2. Indiana State Government. Family and Social Services Administration. Retrieved August 9, 2022 from www.in.gov/fssa.
3. 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.

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