# Administrative Policy Statement
# INDIANA MEDICARE ADVANTAGE

| Policy Name | Policy Number | Date Effective |
|---|---|---|
| Continuity of Care | AD-0935 | 01/01/2021 |
| **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.

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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 (AAFP) 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 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 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:** 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.
- **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 Continuity of Care 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 (PA) that were approved by the member's original Care Management Organization (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. When a health partner is terminated from the CareSource network and that termination was not related to a fraud or quality of care issue;
   B. When a newly enrolled member requests 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 (PA) 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. Inpatient substance abuse treatment
   E. Renal Dialysis Services
   F. Communicable disease services, including STI and HIV testing
   G. 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
      1. All prior authorizations approved by Medicaid Fee for Service (FFS) will be honored.
   C. Extended Care or Skilled Care
   D. 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 will be subject to a medical necessity review.
   E. Home Health Services
   F. Private Duty Nursing
   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 and are hospitalized in **ANY** facility will remain the responsibility of the current CMO at the time of transition, including all professional services, until the member is discharged from the facility for the current admission.
   B. Nursing Facility Care
      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 one of the following occurs:
         a. The member is in the third trimester and has established a relationship with an obstetrician and/or delivery hospital.
         b. The member is in the first or second trimester, has an established relationship with an obstetrician and has a high risk condition, such as preterm labor requiring progesterone therapy.
   D. Postpartum Care
      1. Mothers will be covered for postpartum care for up to 12 weeks following delivery with the non-participating provider (or associate within the provider group) who performed the delivery.
   E. Dialysis
   F. Chemotherapy and Radiation Therapy
      1. When a member has been placed in a chemotherapy and/or radiation treatment plan and until the 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, including scheduled inpatient or outpatient surgeries approved and/or pre-certified.
   I. 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.

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 sign a Single Case 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** | 10/14/2020 | |
| **Date Revised** | | |
| **Date Effective** | 01/01/2021 | |

## 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].

**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*