ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Continuity of Care-GA MCD-AD-0749	06/01/2024
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.

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** – A set of member-centered, goal-oriented, culturally relevant, and logical steps to assure members receive needed services in a supportive, effective, efficient, timely, and cost effective manner, including case management, disease management, transition of care, and discharge planning.
- **Chronic Condition** – Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least 12 months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is considered routine care.
- **Non-Participating Provider** – A provider who has not entered into a contractual arrangement with CareSource, also known as an out-of-network provider.
- **Participating (In-Network) Provider** – A healthcare provider or other organization who has entered into a contractual arrangement or agreement with CareSource to provide certain covered services or administration functions.
- **Primary Care Provider (PCP)** – A licensed healthcare practitioner, who within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all primary care services to members, including general/family practitioners, pediatricians, internists, OB/GYNs, physician assistants, or nurse practitioners and specialists selected by members with chronic conditions with whom the member has an on-going relationship.
- **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 practioners 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. Upon transferring to CareSource, newly enrolled members who have established relationships with providers will be allowed care for 30 calendar days for the following:

1. prior authorizations (pa) received from other payers for services
2. care from a non-participating health partner who treated the member prior to enrollment

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

C. Members who are pregnant when enrolling with CareSource may continue to receive prenatal care through 6 weeks postpartum with a non-participating provider if prenatal care began prior to enrollment or members with a history of high-risk pregnancy elect to receive care from the non-participating provider who provided care for a previous high-risk pregnancy. This coverage extends to other providers who are part of a non-participating physician group and to newborns for 90 days from birth.

D. Some of the following services may result in COC authorization beyond 30 days after medical necessity review. Priority for COC service review will be given to members experiencing the following:

1. medically necessary transportation on a scheduled basis
2. physical therapy, speech therapy, occupational therapy, and/or rehabilitation therapy
3. inpatient and/or outpatient behavioral health care
4. inpatient substance abuse treatment
5. home health services
6. specialized medical care, surgical care, or medical hospitalization
7. specialized durable medical equipment
8. dialysis
9. chemotherapy and/or radiation therapy
10. long-term care facilities, including extended, skilled care, and psychiatric residential treatment facilities
11. hospice

12. orthodontic or dental care
13. post-emergency care
14. organ or tissue transplantation services in process or authorized

III. Continuity of care requests for services from non-participating specialists will be determined based on the treatment plan received. When participating providers are not available to provide needed services after the initial determination, the authorization period may be extended.

IV. Upon notification members will be transitioning from CareSource to a new CMO or to fee-for-service Medicaid, CareSource will work with the new payer to ensure coordination of care and appropriate discharge planning, if applicable.

V. Outcomes of continuity of care requests will be communicated in writing to the member and appropriate provider.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

DATES		ACTION
Date Issued	09/18/2019	
Date Revised	04/01/2023 02/14/2024	Annual review. Annual review. Revised definitions (GA contract language). Reformatted policy sections. Approved at Committee.
Date Effective	06/01/2024	
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 September 7, 2023. www.who.int
2. Coordination and Continuity of Care, 42 CFR § 438.208 (2023).
3. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
4. Managed Health Care Plans, GA. CODE ANN. § 33-20A-61 (2023).
5. Standards for Certification, GA. CODE ANN. § 33-20A-5 (2023).