ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Continuity of Care-IN MCD-AD-0743	07/01/2024
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.

C. Definitions
- **Acute Condition** – A medical or behavioral health (BH) condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem requiring prompt medical attention and with a limited duration.
- **Chronic Condition** – A medical or BH condition due to a disease, illness, or other medical problem that is complex in nature, persists without cure and/or worsens over an extended period or requires ongoing treatment to maintain remission or prevent deterioration.
- **In-Network (Network) Provider** – Any provider, group of providers, or entity that has a network provider agreement with CareSource or a subcontractor and receives Medicaid funding directly or indirectly to order, refer, or render covered services.
- **Level-of-Care (LOC)** – The outcome of the measure of an individual's care needs, including nursing home or institutional placement needs of an individual.
- **Out-of-Network Provider** – Any provider, group of providers, or entity not directly or indirectly employed by or does not have a provider agreement with CareSource or any of its subcontractors.
- **Primary Care** – All health care and laboratory services furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/ gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes the service. [42 CFR 438.2].
- **Primary Medical Provider (PMP)** – Also called a Primary Care Physician (PCP), a PCP or other licensed health practitioner practicing in accordance with state law who is responsible for providing preventive and primary health care to patients, initiating referrals for specialist care, and maintaining the continuity of patient care. At a minimum, providers allowed to serve as PMPs must include physicians, physician assistants, and advanced practice registered nurses.
- **Specialist** – A Board-eligible or certified physician who declares him/herself as a specialist and practices a specific medical specialty. For the purposes of this

definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

- **Terminal Illness** – 6-month or less life expectancy if the illness runs a 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 that consistent healthcare services are delivered through proper coordination combined with information sharing among providers to enhance a patient focused approach. Requests will be accepted from a member, a member's representative, or a provider on behalf of a member. CareSource follows Indiana Health Coverage Programs (IHCP) requirements to facilitate the exchange of member-specific data and ensure facilitiation of care among all stages to enrollment or termination completion. All transitions of care between healthcare settings will be handled according to IHCP requirements, including care coordination guidance, discharge planning, and followup with providers/members, particularly regarding outpatient followup after inpatient discharge. Critical continuity of care areas include, but are not limited to:

A. members receiving HIV, Hepatitis C and/or behavioral health services, especially when a PA was received from a previous payer
B. pregnant members
C. members transitioning into the Hoosier Healthwise or HIP program from traditional fee-for-service or into HIP from Hoosier Healthwise
D. members transitioning between managed care entities, particularly during an inpatient stay
E. members transitioning between IHCP programs, particularly when a HIP member becomes pregnant or disabled
F. members exiting the Hoosier Healthwise or HIP program to receive excluded services
G. members transitioning to a new PMP
H. members transitioning to private insurance, Marketplace coverage, or no coverage
I. members transitioning between HIP plans

II. COC services will be provided when **ONE** of the following occurs:

A. Newly enrolled, CareSource members may qualify for COC coverage in the following circumstances:
1. The member chooses to receive care from an out of network provider. Coverage will be extended as follows:
a. eligibility for 180 days if the provider was providing treatment prior to enrollment.
b. eligibility during the 30-day transition period.

c. pregnant women in the 3rd trimester throughout prenatal, delivery, and postpartum periods or women with a history of high risk pregnancy who want to see a treating provider from a previous high risk pregnancy.

2. The member is or will be receiving services for which a prior authorization (PA) was received from another payer. Services will be provided for 180 days. The date of member enrollment for purposes of the PA time frames begins on the date CareSource receives the member's fully eligible file from the State. Authorization extends to any service or procedure previously authorized, including, but not limited to, the following:
   a. surgeries and therapies
   b. home health
   c. physician services

B. Terminations of contractual relationships between CareSource and providers, provider groups, or entities will result in changes to provider network status. Termination requests will be reviewed 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 60 days.

C. Inpatient stays will be handled in the following manner:
   1. For reimbursements based on diagnosis-related group (DRG) methodology, the admitting managed care entity (MCE) is responsible for the entire inpatient stay through member discharge or ineligibility for medicaid, including the hospital DRG payment and any outlier payments (without a capitation payment). If the member is transitioning from the admitting MCE to another MCE or traditional Medicaid, the admitting MCE will provide care coordination, including coordination of discharge plans, with the receiving MCE or inpatient provider, as applicable.
   2. For reimbursement based on a level-of-care (LOC) methodology, the admitting MCE is responsible for the days during which the member is enrolled with the MCE and the transition of care coordination for the remainder of the stay. The admitting MCE is financially responsible for the per diem payments and any outlier payments (without capitation payment) associated with the days the member remains enrolled with the admitting MCE. If the member is transitioning from the admitting MCE to another MCE or to traditional Medicaid, the receiving MCE or traditional Medicaid program is responsible for the per diem payments associated with the days the member is enrolled with the receiving MCE or in traditional Medicaid until the member is discharged from the hospital or eligibility for Medicaid terminates. The admitting MCE is responsible for the transition of care coordination with the receiving MCE or the inpatient provider, as applicable.

III. To coordinate care and facilitate transition, COC services will be provided for 180 calendar days, including out of network providers, but the following may be subject to a medical necessity review:
   A. 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.
F. post-emergency care (covered 30 days without a medical necessity review after member sees an out of network provider in an emergency department)
G. home health services
H. specialized medical care requiring ongoing care from specialists
I. specialized durable medical equipment, including ventilators and other respiratory assistance equipment

E. Conditions of Coverage

If an out of network provider's services meet medical necessity and the COC policy, CareSource will work to obtain a single case agreement (SCA) document.

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATES	ACTION
Date Issued	04/01/2020	
Date Revised	08/17/2022 02/14/2024	Updated in line with UM P&P. Editorial revisions. Annual review. Definitions updated to contract. Added contract language to D.I., added D.II.C. Updated F. and G. Approved at Committee.
Date Effective	07/01/2024	
Date Archived		

H. References

1. *CareSource Indiana Medicaid Provider Manual*. CareSource; 2023. Accessed January 31, 2024. www.caresource.com
2. Continuation of Care Provisions, IND. CODE § 27-13-36-6 (1998).
3. Continuity of Care and Referrals when Specialty Care Warranted, IND. CODE § 27-13-37-3 (1998).
4. *Healthy Indiana Plan Policies and Procedures Manual*. Indiana Health Coverage Programs. Revised January 24, 2024. Accessed January 31, 2024. www.in.gov
5. Managed Care, 42 C.F.R. §§ 438 (2024).
6. Problems with Continuity of Care, Reporting, IND. CODE § 12-24-12-4 (1994).
7. Special Rules for Ambulance Services, Emergency and Urgently Needed Services, and Maintenance and Post-Stabilization Care Services, 42 C.F.R. § 422.113 (2024).
8. Standards for Continuity of Care, IND. CODE § 27-13-36-11 (1998).
9. State Plans for Medical Assistance, 42. U.S.C. § 1396a(e)(5) (2024).

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