Humana Healthy Horizons in Louisiana

LA.CLI.013 Continuity of Care and Care Transitions

Original Date:	01/20/2025	Accountable Dept.:	LA Medicaid Utilization Management
Last Reviewed Date:	10/01/2025		

Summary of Changes:

10/06/2025: Annual Review: Minor grammatical changes and restructure of policy content.

Scope:

This policy applies to all Humana Healthy Horizons® in Louisiana (Plan) associates who administer, review, or communicate covered physical and behavioral health benefits and services to eligible enrolled members.

Policy:

The Plan will ensure continued access to services for members transferring from another Managed Care Organization (MCO) or a Fee-for-Service (FFS) Program to the Plan as a new member, and to those disenrolling from the Plan and transferring to another MCO or to the FFS Program, or in the event of a not for cause provider termination.

The Plan allows members to maintain their current providers (including out-of-network providers) and prior authorized services for a period of at least ninety (90) days. During the 90-day continuity of care period, the Plan may change the member's existing provider when:

- The member requests a change in provider;
- The provider chooses to discontinue providing services to the members as currently allowed by Medicaid;
- The Plan or the Louisiana Department of Health (LDH/State) identifies provider performance issues that affect the members' welfare;
- The provider is or becomes excluded under State or Federal exclusion requirements.

If a Plan member has exhausted their current benefits and the member continues to need care, the Plan will notify the member about alternatives, other resources, and provide guidance or assistance as needed in obtaining services.

The Plan will permit Indian members to obtain covered services from out-of-network Indian Health Care providers from whom the member is otherwise eligible to receive services.

Procedures:

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The Plan standard Continuity of Care (COC) period is 90 calendar days from the effective date of the member's benefit plan start date for new members, as well as after provider termination, unless the requested services require a longer COC period. The type of service and/or the medical necessity review of the submitted clinical information will determine the need for a longer COC period. Efforts are made by both the Plan's Care Management (CM) and Utilization Management (UM) associates to ensure members continue to receive the necessary services during either of these time periods.

The Plan works to proactively identify members who need COC through activities, such as:

- Distributing COC forms with a self-addressed stamped envelope in the member Welcome Packets. When returned, these forms are scanned into the clinical documentation system and referrals are sent to CM, as appropriate. If a new member contacts Member Services requesting COC, the Member Services team will complete a COC request for the member and refer to CM, as appropriate.
- Requesting clinical documentation from relinquishing MCO's when a new member transitioning to the Plan is identified as being engaged in CM from the transition report. The clinical documentation requested may include: the plan of care, CM assessments, current medications, current contact information (address/phone), and current service authorizations.
- Reviewing historical and transition prior authorization files to identify any open authorizations.
- When a request for authorization or record of prior services from a previous MCO is received by the UM associates, it is reviewed for member COC needs. UM reviewers are provided with resources to assist with identification of services that require a COC period.
    - Inpatient or Outpatient Surgery
        - The Plan covers scheduled inpatient or outpatient surgeries previously approved, whether the treating provider is in or out of network with the Plan. Surgical procedures also include follow-up care as appropriate.
    - Pregnancy
        - In the event a new member is in the first trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of enrollment, the Plan will be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care. These services do not require prior authorization, regardless of the network status of the provider until the Plan can reasonably transfer the member to a network provider without impeding service delivery that might be harmful to the member's health.
        - In the event a new member is in the second or third trimester of pregnancy and is actively receiving medically necessary covered prenatal care services at the time of enrollment, the Plan will be responsible for providing continued access to the prenatal care provider for 60 calendar days post-partum, provided the member remains covered through the Plan, or referral to a safety net provider if

the member's eligibility terminates before the end of the post-partum period. These services do not require prior authorization.

- Ongoing Chemotherapy or Radiation
  - The Plan will provide coverage for the services to the member regardless of the treating providers network status with the Plan or whether services were prior authorized.
- Outpatient Services
  - The Plan will provide coverage for members to receive services from their current providers regardless of their network status with the Plan including prior authorized services for a period of at least 90 days.
- Behavioral Health Therapeutic Medication Classes

The Plan will cover the behavioral health therapeutic medication classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine/Naloxone and Naltrexone products) prescribed to the member in a mental health treatment facility. The Plan will cover behavioral health therapeutic medication classes for at least 60 calendar days after the facility discharges the member, unless the Plan's psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are not medically necessary or potentially harmful to the member.

- Inpatient Hospital Stay

If a member is transferred between MCOs, but is hospitalized at the time, the transfer will be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the member is discharged. The receiving MCO is responsible for all other care.

- Other Specialized Services:
  - Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition.
  - Members who have conditions requiring ongoing monitoring or screening, such as elevated blood lead levels and members who were in the neonatal intensive care unit (NICU) after birth.
  - Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, or chronic illness resulting in hospitalization.

UM associates will check each received request for authorization to ensure the provider's patient has active Medicaid benefits with the Plan, including if the member's plan start date is within the last 90 days. When the member is identified as potentially needing continuity of care, the UM associate will document these findings in the member's service authorization request.

- The UM Reviewers will review all available documentation to verify the member qualifies for COC. If the UM Reviewer cannot determine the need for COC based on the provided documentation, outreach will be conducted to the provider to assess the need for COC.
- Once a request is determined to meet COC guidelines, request for authorization will follow the approval process.
- The Plan does not deny requests for authorizations, within the COC period, solely on the basis that the provider is an out of network provider.
- UM Reviewers will make appropriate CM referrals for members who are within the COC period for coordination of in network services once it is determined that transition is safe and appropriate under the following circumstances:
    - Pregnancy and/or Postpartum (within 60 days postpartum) members
    - Prior-authorized surgery
    - Transplant
    - Ongoing chemotherapy or radiation treatment
    - Hospitalization
    - Private duty nursing, home care services, and durable medical equipment (DME)
    - Assisting Members with Termed Providers
    - When a provider voluntarily elects to end their contract with the Plan, a written notification is sent to the member. This notification provides guidance for the member on how they can contact the Plan for assistance with any COC needs, as well as assistance finding an in-network provider.
    - If a member calls Member Services to request COC with the termed provider, a Member Services associate will assist them in completing the COC form and refer to CM for assistance with care coordination.

Definitions:

Care Coordination – Deliberate organization of patient care activities by a person or entity, including the Contractor that is formally designated as primarily responsible for coordinating services furnished by providers involved in the member's care, to facilitate the appropriate delivery of health care services. Care coordination activities may include but are not limited to the coordination of specialty referrals, assistance with Ancillary Services, facilitating service authorization requests, and referrals to and coordination with community services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of the member's care.

Care Management – An overall approach to managing member's care needs and encompasses a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage health conditions.

Case Manager – A licensed registered nurse, licensed mental health practitioner, or other trained individual who is employed or contracted by the Contractor or a member's PCP. The case manager is accountable for providing intensive monitoring, follow-up, clinical management of high risk members, and care coordination activities, which include development of the Plan of Care, ensuring appropriate referrals and timely two-way transmission of useful member information; obtaining reliable and timely information about services other than those provided by the PCP; supporting the member in addressing social determinants of health; and supporting safe transitions in care for members moving between institutional and community care settings. The case manager may serve on one or more multi-disciplinary care teams and is responsible for coordinating and facilitating meetings and other activities of those care teams.

Network –The collective group of providers who have entered into Provider Agreements with the Contractor for the delivery of MCO Covered Services. This includes, but is not limited to physical, behavioral, pharmacy, and Ancillary Service providers. Also referred to as Provider Network.

Out-of-Network (OON) Provider- An individual, facility, agency, institution, organization, or other entity that has not entered into a contract with the Contractor for the delivery of MCO Covered Services to the Contractor's members.

Prior Authorization –The process of determining medical necessity for specific services before they are rendered.

Version Control:

2/8/22: Policy Creation-Approved by LDH for Readiness
5/15/23: Approved by LA UM Committee
9/26/23: Changed to new template for Annual Review Due by 5.15.24. KWise, MCD Clinical Delivery Experience
10/28/2024: Annual Review, minor grammatical changes and updated references to the most recent edition reviewed. Updated language to the most recent edition.
1/20/2025: Approved by LDH.

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References:

Louisiana Department of Health Bureau of Health Services Financing. Louisiana Medicaid Managed Care Organization Attachment A: Model Contract. 2.8-Continuity of Care, 2.12-Service Authorizations for New Enrollees, 5.1.4-Identify and Maintain Sufficient Key Personnel and Support Staff Based in Louisiana (1/1/2023). Accessed (10/06/2025).

Louisiana Department of Health. Louisiana Medicaid Managed Care Organization (MCO) Manual (8/15/2024). Accessed 10/06/2025).

NCQA Health Plan Accreditation Standards NET 4

List any reference documents here that readers could review for more information regarding this Procedure (including a link to the document).

Owner:	Brandy Holmes	Executive Team Member:	Calder Lynch
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