	DEPARTMENT:	Case Management
	SUBJECT:	Continuity and Coordination of Care
	PRODUCT LINE:	All
	POLICY NUMBER:	012
	ORIGINAL POLICY EFFECTIVE DATE:	06/20/06
	LAST REVISED DATE:	3/27/2026
	LAST REVIEWED DATE:	3/27/2026

POLICY:

Group Health Cooperative of Eau Claire monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network to meet the diverse needs of our members.


SCOPE:

GHC has systems and processes in place to ensure coordination and continuity of care to improve health outcomes for members. The following systems/processes are used to coordinate care:

1. Care is managed and coordinated through the member primary care provider whenever possible.
2. An electronic care management system is in place to document prior authorizations, care coordination activities including referrals, and all member contacts and ensures staff have access to information that directly impacts access to services.
3. Education on how to access care in emergency situations.
4. Health management staff conduct comprehensive clinical assessments to determine members' care needs and develop a care plan with interventions and goals to address the member's needs and will aid in determining the medical appropriateness of all transitions of care for the member including new enrollees.
5. Staff review for underutilization of preventive services and encourage members and providers to complete these services.
6. Utilization management staff will work in conjunction with the case management staff to ensure that prior authorization requests or transition of care into the network whenever possible is completed timely, within required timeframes, and with as little disruption as possible to ensure the member's care needs are met and according to continuity standards.
7. To improve care coordination, GHC has letter of agreements with counties and coordinates the member's care with the following agencies (but not limited to): ADRC's, Prenatal Care Coordination services, WIC, Birth to Three, NEMT transportation services, community agencies, and drug court services.
8. Health management processes for continuity and coordination of care utilize evidence based national clinical practice guidelines, HEDIS measures, and clinical literature to ensure processes are objective. Benefits are also administered according to the respective product line.
9. GHC facilitates coordination of care/services using a team-based approach by assisting with referrals, transfer of medical records and clinical information, providing resources and support, and connecting members to community and county resources.

GHC coordinates the services the HMO provides to the member and in the following circumstances:

- a. Between settings of care, including appropriate discharge planning for hospital or institutional stays
- b. With services provided by another HMO
- c. With services a member receives through Medicaid Fee-for-Service
- d. With services a member receives through community and social support providers

	DEPARTMENT:	Case Management
	SUBJECT:	Continuity and Coordination of Care
	PRODUCT LINE:	All
	POLICY NUMBER:	012
	ORIGINAL POLICY EFFECTIVE DATE:	06/20/06
	LAST REVISED DATE:	3/27/2026
	LAST REVIEWED DATE:	3/27/2026

PROCEDURE:

Continuity and Care Coordination -New Enrollees

GHC helps new enrollees transition to in-network providers whenever feasible. If services cannot be provided by an in-network provider, then services may be approved upon submission and review of an OON prior authorization to ensure a smooth transition for new enrollees and to ensure continued access to previous services when the absence of continued services would pose serious health risks or hospitalization, GHC will authorize, through the prior authorization process, coverage of all medically necessary medical, behavioral, and therapeutic services with the member’s current providers for the first 90 days of enrollment. During this transition, we will work with the member to identify providers in our network that they can transition their care to and will help coordinate appointments. GHC will also approve prior authorizations at the utilization level previously authorized for 90 days. Exceptions to the 90-day requirement are allowed in situations where the member agrees to change providers, the member agrees to a lower level of care, or if the HMO can document that continuing the care would result in abuse, safety, or quality concerns. This does not extend authorizations beyond the time or visits previously approved, nor does this apply to any in-lieu of services.


Through health risk assessments initial SSI assessment, DSNP HRAT, commercial HRA, and health needs assessment for BadgerCare Plus members, we identify members who require coordination of services as new enrollees. When we identify a new member who is receiving out of network services, we educate them on our process and notify our utilization department so they can start coordinating services. Lastly, because of our extensive provider network, we do not have many continuity of care issues for new enrollees.

Medicaid Members Only

We identify members who that have a current FFS authorization for any service from the data feed that DHS provides to HMOs. These prior authorizations are integrated into our current electronic care management system and can easily identify who has a current prior authorization in place and can easily coordinate prior authorizations for our new enrollees. GHC will authorize continued access to previous services when the absence of continued services would pose serious health or hospitalization risks and would work to transition services based on member’s clinical status and current national clinical practice guideline standards as health risk status stabilizes and when applicable.

Continuity and Care Coordination - Member Disenrollment

When members transition off plan or eligibility ends, health management staff work with the member to ensure a smooth transition to a new HMO by making appropriate referrals and by assisting in the transfer of medical records to new providers as described in the section below entitled, “Transfer of Medical Records.”

	DEPARTMENT:	Case Management
	SUBJECT:	Continuity and Coordination of Care
	PRODUCT LINE:	All
	POLICY NUMBER:	012
	ORIGINAL POLICY EFFECTIVE DATE:	06/20/06
	LAST REVISED DATE:	3/27/2026
	LAST REVIEWED DATE:	3/27/2026

Continuity and Care Coordination - Provider Termination

GHC helps members transition to a new in-network provider when a member’s current in-network provider leaves our network. As part of this transition, GHC allows continuation of medically necessary treatment when prior authorized:

1. Through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.
2. through the postpartum period for members in their second or third trimester of pregnancy.
3. For BadgerCare Plus and SSI, GHC will also provide coverage to a member for the services of a provider, regardless of whether the provider is in-network at the time the services are provided, if GHC represented that the provider was a participating provider in marketing materials provided to members during the most recent enrollment period. In these circumstances, coverage will be provided for primary care physicians, until the end of the contract year for which it was represented that the provider was participating in the GHC network.

Coverage is not provided or may be discontinued if any of the following apply:

1. The provider no longer practices in the GHC’s geographic service area.
2. The provider was terminated for misconduct or quality issues.

When a member’s provider leaves the GHC provider network, health management staff assists the member with finding a new provider as well as ensure continuity of care. A letter is sent to the member notifying them that their provider is no longer in network and outlines how to find a new in-network provider and the provisions of continuity and care coordination.


Covered Benefit Limitations and Transition to Other Care

When a member’s covered benefit is exhausted and the member continues to need care, GHC notifies the member about alternatives and resources for continuing care and how to obtain it, as appropriate. Clinical situations when this is done include:

- Autism benefits
- Prior authorization requests for services that are beyond the benefit limit. Prior authorization requests that are related to a benefit limit are entered as a review type of “Benefit Exhaustion” for reporting purposes.

Transfer of Medical Records

Upon member or provider request, GHC assists members and helps facilitate transfer of medical records according to HIPAA privacy rules during transitions of care (transitions between providers including county health departments, health plans, and levels of service) to ensure continuity of care. Direct provider-to-provider exchanges are permitted if both providers are in agreement. It is then the responsibility of the agreeing providers to administrate the member medical record transfer, including HMO notification of the transfer. Requests for records are received by phone, mail, email, or fax and are processed by the case

	DEPARTMENT:	Case Management
	SUBJECT:	Continuity and Coordination of Care
	PRODUCT LINE:	All
	POLICY NUMBER:	012
	ORIGINAL POLICY EFFECTIVE DATE:	06/20/06
	LAST REVISED DATE:	3/27/2026
	LAST REVIEWED DATE:	3/27/2026

manager. Medical records are transmitted according to HIPAA privacy rules and would be sent by fax, email, or mail.

GHC participates in Wisconsin Statewide Health Information Network (WISHIN), the state-designated entity for health information exchange, to facilitate exchange of medical records between health plans and providers. Participation includes subscribing to the WISHIN Pulse community health record, submitting a member roster as specified by WISHIN, and subscribing to the WISHIN Patient Activity Report (PAR) and submitting member care plans for SSI members.

GHC would share (with new health plan or new provider) results of its identification and assessment of any member with special health care to avoid duplication of activities and ensure member's health needs are met in a timely manner without interruption of services.


Medical Record Documentation Review

Medical documentation is crucial for ensuring quality and continuity of member care and facilitating communication among healthcare entities. To ensure practitioners maintain and share, as appropriate, a member health record and document in accordance with professional standards, medical record reviews occur during HEDIS chart reviews. GHC QI staff look for opportunities for medical record documentation improvement. When issues are identified, GHC QI staff follow up with the provider to correct documentation issues. Medical records received through the prior authorization process are reviewed for accurate documentation. When issues are identified, these are addressed with the provider.

Health management staff helps members during transitions of care by coordinating services and processes and ensuring accurate clinical documentation during these transitions. The utilization management staff reviews documentation and coordinates services prior to surgeries and elective admissions to evaluate not only the medical necessity of the service but also to educate the member on what to expect during the transition. Clinical documentation is reviewed during the prior authorization process for elective surgeries and helps identify opportunities to optimize the member's health pre-operatively for a quality surgical outcome. Transitions from hospital to SNF or home are also reviewed through the concurrent review process. This enables staff to review accuracy of the health information (including medication reconciliation at time of discharge) and help arrange services to meet the member's needs and create a successful transition. The health management staff works in conjunction with the member's primary care provider, hospital discharge staff, home health agencies, and SNF staff as well as community and county agencies and facilitates accurate health information to all parties involved in the transition. If there are inaccuracy in the medical record, staff will call to clarify and help correct misinformation to maintain an accurate medical record.

Privacy Rules

In the process of coordinating care and transfer of medical records or other health care information, members' rights are protected according to HIPAA privacy rules.

	DEPARTMENT:	Case Management
	SUBJECT:	Continuity and Coordination of Care
	PRODUCT LINE:	All
	POLICY NUMBER:	012
	ORIGINAL POLICY EFFECTIVE DATE:	06/20/06
	LAST REVISED DATE:	3/27/2026
	LAST REVIEWED DATE:	3/27/2026

APPROVED: *Michele Bauer MD*

DATE: 3/27/2026

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
02/18/2013	Carol E. Ebel, RN HM Mgr.	This is a continuation of the archived P & P.
02/15/2014	Lynne Komanec, RN HM Manager	Reviewed with no changes
09/02/2014	Lynne Komanec RN	Added information on county services with a link.
09/25/2017	Michele Bauer, MD, CMO	Reviewed with no changes.
03/18/2018	Michele Bauer, MD, CMO	Added process for new SSI enrollees
6/11/2019	Michele Bauer, MD, CMO	Updated GHC process section
7/1/2020	Michele Bauer, MD, CMO	Reviewed no changes.
8/30/2021	Michele Bauer, MD, CMO	Updated continuity process when providers leave the network and added processes for NCQA standards
8/30/2022	Michele Bauer, MD, CMO	Reviewed. No changes.
8/30/2023	Michele Bauer, MD, CMO	Reviewed. No changes.
4/5/2024	Michele Bauer, MD, CMO	Updated process for medical record transfer
6/4/2024	Michele Bauer, MD, CMO	Updated process with DHS contract
5/1/2025	Michele Bauer, MD, CMO	Added our process for medical record documentation review
8/27/2025	Michele Bauer, MD, CMO	Updated the QI Initiatives Related to Continuity and Coordination NCQA standards.
3/27/2026	Michele Bauer, MD, CMO	QI initiatives related to continuity of care were removed and will be documented in the QI Program policy.