ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Continuity of Care-AR PASSE-AD-0992	01/01/2023-12/31/2023

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) 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, including practitioners and general acute care hospitals, terminates an 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 an old plan to CareSource or from a terminated provider to a CareSource participating provider.

The American Academy of Family Physicians (AAFP) defines COC 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 and medical outcomes while reducing healthcare costs.

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 requiring prompt medical attention with 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.
- **Continuity of Care** - A process for assuring care is delivered seamlessly across a multitude of delivery sites and transitions in care throughout the course of the disease process.
- **Non-Participating Provider** - A provider who has not entered into a contractual arrangement with CareSource, also known as an out-of-network provider.
- **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. 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.
- **Person-Centered Service Plan (PCSP)** - A total plan of care for the member that includes services necessary for the member, any specific needs the member has, the members needs and strengths and a crisis plan for the member.
- **Postpartum Period** - A span of at least 60 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.
- **Primary Care Provider (PCP)** - A network physician, network physician group, advanced practice nurse or advanced practice nurse group trained in family medicine

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(general practice), internal medicine, or pediatrics responsible f or providing and/or coordinating all covered services for network benefits.
- **Terminal Illness** - An illness with a life expectancy of 6 months or less 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 consistent healthcare services are delivered through proper coordination combined with information sharing among providers and PASSE entities in order to enhance a patient focused approach. COC services will be provided for at least 90 days when the criteria in this policy are met and a member, in absence of services, would suffer serious determent to his/her health or be at risk of hospitalization or institutionalization. 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 any of the following occurs:
   A. When a provider is terminated from the CareSource network.
   B. When any member is disenrolled from a PASSE for any reason other than ineligibility for Medicaid.
   C. When a member is transitioning from fee for service (FFS) to a PASSE entity.
   D. When a member is transitioning from one PASSE to another.

III. COC services will include the following:
   A. All service authorizations that were previously authorized by another PASSE will be honored for up to 90 days or until a new PCSP can be developed.
   B. When a member transitions to another PASSE, CareSource care coordinators will ensure timely notification to the new PASSE of the member's special needs, medical records, PCSP, treatment plans, and care coordination files.
   C. When a member transitions from another PASSE, CareSource care coordinators will ensure:
      1. The member is assigned to a local care coordinator.
      2. Continuation of care coordination to prevent disruption of services.
      3. Coordinate services to ensure a smooth transition and COC for 90 days or until transition is completed, whichever is longer. This coordination also includes PCSP.
   D. The member will have access consistent with the access he/she previously had and is permitted to retain current provider for at least 90 days if that provider is not in the current network.
   E. The member will be referred to appropriate providers of services in the current network.
   F. All members who have an existing PCSP will retain that care plan when enrolled into a new PASSE and care coordinators will update as needed and appropriate.

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IV. CareSource will ensure members with the following conditions are addressed in a timely manner:
   A. Members living in their own home who have significant conditions or treatments, such as:
      1. Pain control
      2. Hypertension
      3. Enteral feedings
      4. Oxygen
      5. Wound care
      6. Ventilators
   B. Members receiving ongoing services, such as:
      1. Intellectual and developmental disabilities services
      2. Serious mental illness services
      3. Daily in-home care
      4. Crisis behavioral health care
      5. Dialysis
      6. Home health
      7. Specialized pharmacy prescriptions
      8. Medical supplies
      9. Chemotherapy
      10. Radiation therapy
      11. Members who are hospitalized at the time of transition
   C. Members who have received prior authorization for services, such as:
      1. Scheduled surgeries
      2. Post-surgical follow up visits
      3. Therapies to be provided after transition
      4. Out-of-area specialty services
   D. Members who have significant medical conditions requiring ongoing monitoring or screening.

E. Conditions of Coverage

- Nonmedical community supports and services (NCSS) are provided to prevent or delay admission to an institutional setting or to assist with preparation for a member to leave an institutional setting.
- Nonmedical community supports and services (NCSS) are available under federal authority in sections 1905, 1915(c), and/or 1915(i) and included in the PASSE program created under Arkansas Act 775. The service should assist the individual to live safely and successfully in his/her own home or in the community. NCSS must be rooted in specific member needs found identified through the Independent Assessment leading to placement in the PASSE and included within an individually created Person-Centered Service Plan (PCSP). NCSS should be reviewed and updated regularly through the care coordination and PCSP process. NCSS are not medical in nature but instead support pursuit of safe independent living and member goals clearly established in the member's PCSP.

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F. Related Policies/Rules

NA

G. Review/Revision History

	DATES	ACTION
Date Issued	06/09/2021	New policy.
Date Revised	09/28/2022	Editorial changes. Reviewed and updated references. Note added regarding nonmedical community support services.
Date Effective	01/01/2023	
Date Archived	12/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Division of Medical Services. Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual. Retrieved on September 19, 2022 from www.humanservices.arkansas.gov.
2. Provider-Led Arkansas Shared Savings Entity Provider Agreement Between CareSource and The Department of Human Services For the Service Delivery Period January 1, 2021 through September 30, 2021. Retrieved on September 19, 2022 from www.humanservices.arkansas.gov.

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