ADMINISTRATIVE POLICY STATEMENT Arkansas PASSE	
Policy Name & Number	**Date Effective**
Continuity of Care-AR PASSE-AD-0992	01/01/2024
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 condition, illness, or disease having a short and relatively severe course.
- **Course of Treatment** - A prescribed order or ordered course of treatment for a specific individual with a specific condition that is outlined and decided upon ahead of time and may, but is not required to, be part of a treatment plan.
- **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 agreed to provide healthcare services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from the payer.
- **Person-Centered Service Plan (PCSP)** - A total plan of care for the member that includes necessary services, specific member needs, member strengths, and a crisis plan for the member.
- **Serious and Complex Condition** - In the case of (1) an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, a condition that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

D. Policy
I. COC service requests will be accepted from members or providers/representatives on behalf of members and will be provided for at least 60 days when any of the following criteria are met:
   A. Newly enrolled members, including members transitioning from Fee-For-Service to CareSource PASSE or between PASSE entities under the following circumstances:
      1. Requesting continued services by a current provider:

a. The member will have access to services consistent with previous services and can retain a current provider regardless of that provider's network status, as long as the provider is an Arkansas Medicaid enrolled provider, for 60 calendar days until an appropriate in network provider is found or the PCSP is completed, whichever is longer.
b. The member will be referred to appropriate providers in the PASSE network.
c. All relinquishing PASSE entities will fully and timely provide the receiving PASSE with medical records, PCSP, treatment plans and Care Coordination files within 20 business days and coordinate services with relinquishing PASSE to ensure smooth transition and continuity of care for 60 calendar days or until the transition is completed, whichever is longer. Each PASSE will comply with requests for historical utilization data in compliance with federal and state law and consistent with federal requirements outlined in 42 C.F.R. § 438.62.
d. Existing PCSPs will be honored and carried out until a new CareSource PSCP is created.

2. Prior authorization(s) for services from other entities will be honored for 60 days or until a new PCSP is developed and include the following (not an all-inclusive list):
   a. scheduled surgeries or post-surgical follow-up visits
   b. therapies to be provided after transition
   c. out-of-area specialty services

B. Provider or facility terminations from the CareSource network for reasons other than fraud or quality of care issues:
   1. When a practitioner or practice group in general, family, pediatrics or internal medicine leaves the network, CareSource will make best efforts to notify members at least 30 calendar days prior to the effective termination date and assist the member with the selection of a new practitioner.
   2. CareSource will make best efforts to notify members affected by the termination of a practitioner or practice group providing behavioral health or developmental disability services specialty care at least 30 calendar days prior to the effective termination date or 15 days after receipt, whichever is later. Assitance will be given to the member in order to select a new behavioral health or developmental disability services specialty provider.
   3. Members may also notify CareSource of a COC request due to a provider or facility contract termination.

III. When a CareSource member transitions to another PASSE, CareSource care coordinators will ensure timely notification of the member's special needs, medical records, PCSP, treatment plans, and care coordination files to the new PASSE.

IV. When a member transitions from another PASSE to CareSource, CareSource will ensure the following:
   A. The member is assigned to a local care coordinator.
   B. Coordination of care is conducted to prevent disruption of services.

C. Services are coordinated to ensure a smooth transition including PCSP development.

V. CareSource will ensure that the following members are addressed in a timely manner (not an all-inclusive list):
   A. members living in private residences with significant conditions or treatments, including any of the following:
      1. pain control
      2. hypertension
      3. enteral feedings
      4. oxygen
      5. wound care
      6. ventilators
   B. members receiving ongoing services, such as the following:
      1. intellectual and developmental disabilities services
      2. services for serious mental illness or crisis behavioral health care
      3. daily in-home care
      4. dialysis
      5. home health services or medical supplies
      6. specialized pharmacy prescriptions
      7. chemotherapy and/or radiation therapy
      8. members who are hospitalized at the time of transition
   C. members with significant medical conditions requiring ongoing monitoring or screening

E. Conditions of Coverage
N/A

F. Related Policies/Rules
Medical Necessity Determinations
Non-medical Community Supports and Services
Person Centered Service Plans

G. Review/Revision History

	DATES	ACTION
Date Issued	06/09/2021	New policy.
Date Revised	09/28/2022 10/11/2023	Editorial changes. Reviewed and updated oreferences. Note added regarding nonmedical community support services. Annual review. Updated policy order and reference list. Approved at Committee.
Date Effective	01/01/2024	
Date Archived		

H. References
1. Arkansas Health Care Consumer Act, ARK. CODE ANN. § 23-99-408 (2023).

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

2. Commitment and Treatment, ARK. CODE ANN. § 20-47-201 (2023).
3. Continued Services to Enrollees, 42 C.F.R. § 438.62 (2023).
4. *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
5. Continuity of Care, ARK. CODE ANN. § 23-99-408 (2022).
6. Continuity of care and services to members. *Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual, II: Program Policy*. Division of Medical Services. Updated January 1, 2023. Accessed July 27, 2023. www.humanservices.arkansas.gov
7. Definitions, ARK. CODE ANN. § 23-99-403 (2022).
8. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
9. Patient Right to Know Act, ARK.CODE ANN. § 20-6-202 (2023).
10. *Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement*. Arkansas Dept of Human Services; 2023. Effective January 1, 2023 - December 31, 2026.

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