



ADMINISTRATIVE POLICY STATEMENT

Arkansas PASSE

Policy Name & Number	Date Effective
Continuity of Care-AR PASSE-AD-0992	06/01/2026
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 (PA) 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.

The State of Arkansas publishes additional information regarding COC parameters. Information can be found in Arkansas Code and on the State Department of Human Services website. COC service requests will be accepted by members, providers or other representatives of members. This policy applies to medical services, behavioral health (BH) services and intellectual/developmental disability services (IDD).

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 services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from the healthcare insurer.
- **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 honored for newly enrolled CareSource members for the following time frames:
 - A. transitioning from Fee-For-Service Medicaid for 60 calendar days (CDs)
 - B. transitioning from another PASSE for 90 CDs

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

- II. COC services honored include the following:
 - A. requests for continued services by a current Arkansas Medicaid enrolled provider(s) regardless of network status until an appropriate in-network provider is found or the PCSP is completed, whichever is longer
 - B. prior authorizations for services from other entities until a new PCSP created, including (not all-inclusive)
 - 1. scheduled surgeries or post-surgical follow-up visits
 - 2. therapies to be provided after transition
 - 3. out-of-area specialty services
 - C. 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 or one providing BH or IDD specialty care leaves the network, CareSource will make best efforts to notify members at least 30 CDs prior to the effective termination date or 15 days after receipt, whichever is later. Assistance will be provided to the member in selecting a new practitioner.
 - 2. Members may also notify CareSource of a COC request due to a provider or facility contract termination.

III. Transition Coordination

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 the relinquishing PASSE to ensure smooth transition and COC for the appropriate time periods listed in D.I.A. and B. 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

- A. When a CareSource member transition 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.
- B. When a member transitions from another PASSE to CareSource, CareSource will ensure
 - 1. The member is assigned to a care coordinator.
 - 2. Coordination of care is conducted to prevent disruption of services.
 - 3. Services are coordinated to ensure a smooth transition, including PCSP development.

IV. 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

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- 4. oxygen
- 5. wound care
- 6. ventilators
- B. members receiving ongoing services, such as the following:
 - 1. intellectual and developmental disabilities services
 - 2. Home and Community Based Services (HCBS)
 - 3. services for serious mental illness or crisis behavioral health care
 - 4. daily in-home care
 - 5. dialysis
 - 6. home health services or medical supplies
 - 7. specialized pharmacy prescriptions
 - 8. chemotherapy and/or radiation therapy
 - 9. 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	Editorial changes. Reviewed and updated references. Note added regarding nonmedical community support services.
	10/23/2023	Annual review. Updated policy order and reference list. Approved at Committee.
	10/23/2024	Annual review. Updated references. Approved at Committee.
	02/25/2026	Annual review. Revised COC time period for FFS to 60 days. Updated references. Approved at Committee.
Date Effective	06/01/2026	
Date Archived		

H. References

- 1. Continuity of Care, ARK. CODE ANN. § 23-99-408 (2024).
- 2. Continued Services to Enrollees, 42 C.F.R. § 438.62 (2023).
- 3. Definitions, ARK. CODE ANN. § 23-99-403 (2024).
- 4. Harris E. Review finds benefits of primary care continuity. *JAMA*. 2023;329(24):2119. doi:10.1001/jama.2023.9930
- 5. Legislative Findings and Purpose, ARK. CODE ANN. § 20-6-202 (2024).

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6. *Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement.* Arkansas Dept of Human Services. Effective January 1, 2023 - December 31, 2026. Accessed February 17, 2026. www.caresource.com
7. *Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual, Section II.* Arkansas Division of Medical Services. Accessed February 17, 2026. www.humanservices.arkansas.gov
8. Purpose-Policy, ARK. CODE ANN. § 20-47-201 (2024).
9. Requirements for Health Benefit Plans, ARK. CODE ANN. § 23-99-303 (2024).

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