Policy & Procedure			
Subject:	Continuity of Care		
Policy Number:	153.706	**Page(s):**	~~9~~1~~21~~
Supersedes:		**Attachment(s):**	0

Department:	Utilization Management
Policy Owner:	Utilization Management Manager
Stakeholder(s):	UM, ICM, Network Management, Member Services
Applicable Parties:	All AmeriHealth Caritas Louisiana (ACLA) Associates and AmeriHealth Caritas Family of Companies (ACFC) Associates Representing ACLA

Date Reviewed:	**11/7/2022**	**Original Effective Date:**	08/11/2011
Date Reviewed by Compliance:	**11/7/2022**	**Current Effective Date:**	**1/1/2023**
Next Review Date:	**11/7/2023**	**Review Cycle:**	Annually

Contract Reference(s):	**Louisiana Medicaid MCO Attachment A: Model Contract 2.3.8; 2.8; 2.8.2;2.8.3.5; 2.9; 2.12.7.2.1- 2.12.7.2.3; 2.12.7.5**
NCQA Reference(s):	UM 1: Element A Factor 5, 6

POLICY

ACLA provides continuing coverage of care for Enrollees who are engaged in an ongoing course of treatment with a non-participating Practitioner/Provider and for enrollees determined to need a course of treatment or regular monitoring, to promote continuity of care. In accordance with 42 CFR §438.208(c)(4), ACLA allows enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs in the following situations:

1. Newly Enrolled Pregnant Women

   - Who are receiving medically necessary covered services in addition to, or other than, prenatal services (see below for newly enrolled Enrollees receiving only prenatal services) at the time of becoming an ACLA Enrollee, ACLA will be responsible for the costs of continuation of such medically necessary services, without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. ACLA will provide continuation of such services up to ninety (90) calendar days or until the Enrollee may be reasonably transferred without disruption, whichever is less. ACLA may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, ACLA will not deny authorization solely on the basis that the Provider is not a contracted provider.

     Who are in the first trimester of pregnancy and are receiving medically necessary covered prenatal care services the day before becoming an ACLA Enrollee. The Enrollee

can continue to receive such medically necessary prenatal care services, including prenatal care, delivery, and post-natal care, without prior authorization and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider until such time as ACLA can reasonably transfer the Enrollee to a participating ACLA Practitioner/Provider without impeding delivery that might be harmful to the Enrollee's health.

- Who are in the second or third trimester of pregnancy and are receiving medically necessary covered prenatal care services the day before becoming an ACLA **Enrollee** can continue to receive services from their prenatal care Practitioner/Provider (whether a participating or non-participating ACLA Practitioner/Provider) for sixty (60) calendar days postpartum, provided the Enrollee is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the postpartum period.

2. Newly Enrollees

- Who are receiving medically necessary covered services the day before becoming an ACLA Enrollee, can continue to receive such medically necessary services for the first thirty (30) calendar days of enrollment, without the need for medical necessity review and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. After thirty (30) calendar days, prior authorization requirements apply for those services identified as requiring prior authorization. ACLA will continue to provide coverage for services determined to be medically necessary for an additional thirty (30) calendar days or until the Enrollee may be reasonably transferred without disruption, whichever is less. ACLA will not deny authorization solely on the basis that the Practitioner/Provider is not a participating ACLA Practitioner/Provider.

- Who are receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies at the time of becoming an ACLA enrollee, whether such services were provided by another MCO or Medicaid fee-for-service (FFS), can continue to receive these services, without prior authorization and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. ACLA will continue to provide coverage for services for up to ninety (90) calendar days or until the enrollee may be reasonably transferred to a participating provider without disruption, whichever is less. ACLA will honor any prior authorization for durable medical equipment, prosthetics, orthotics, and certain supplies issued while the Enrollee was enrolled in another MCO or Medicaid fee-for-service for a period of ninety (90) calendar days after the Enrollee's enrollment into ACLA.

Who have special health care needs and are receiving medically necessary covered services at the time of ACLA enrollment, ACLA shall provide continuation/coordination

of services up to ninety (90) calendar days or until the Enrollee may be reasonably transferred to a Network provider without disruption, whichever is less. ACLA may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, ACLA is prohibited from denying authorizations solely on the basis that the provider is a non-contracted provider.

- Who are to be transferred between MCOs but are hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the Enrollee is discharged. The receiving MCO is responsible for all other care.
  Special consideration to be given to, but not limited to, the following:
  - **Enrollees with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;**
  - **Enrollees who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-are specialty services;**
  - **Enrollees who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels or Enrollees who were born prematurely; and**
  - **Enrollees with significant medical conditions such as a high-risk pregnancy or pregnancy within the last thirty (30) Calendar Days, the need for organ or tissue transplantation, or chronic illness resulting in hospitalization.**

- ACLA will provide active assistance to enrollees when transitioning to/from another MCO or to Medicaid FFS in accordance with a transition of care policy that ensures continued access to services during the transition, when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. To include the following:
  - The Enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for 30 days if that provider is not in the ACLA's network.
  - Coordinating care with the relinquishing MCO so services are not interrupted
  - Arranging for continuity of necessary care by making referrals to appropriate providers of services that are in network;
  - ACLA fully and timely complies with requests for historical utilization data from the new MCO or Medicaid FFS in compliance with Federal and State laws, regulations, rules, policies, procedures, and manuals. The Transition report form LDH is received and reviewed monthly to gather and provide appropriate medical records and case management files of the transitioning

member to the accepting MCO. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing contractor.

- ACLA shall be consistent with federal and state law and the enrollee's new provider(s) are able to obtain copies of the Enrollee's health records, as appropriate by contacting the UM department.
- ACLA shall coordinate any other necessary procedures as specified by LDH in writing to ensure continued access to services to prevent serious detriment to the Enrollee's health or reduce the risk of hospitalization or institutionalization.

3. Current Enrollees receiving care from a Practitioner/Provider

   - May continue an ongoing course of treatment (defined as treatment for a chronic or acute medical condition; behavioral health condition; or life-threatening illness) with a Practitioner/Provider whose contract is terminated with ACLA (either by ACLA or by the Practitioner) for up to ninety (90) calendar days from the effective date of the termination. Coverage for the continuation of an ongoing course of treatment will not be provided in the following circumstances:
     - The Practitioner/Provider contract was terminated by ACLA as the result of a professional review action (quality of care issue)
     - The Practitioner/Provider is unwilling to continue to treat the member or accept ACLA's payment or other terms

4. Current Enrollees who are in their second or third trimester of pregnancy or who are identified as having a high-risk pregnancy
5. On the date that the Enrollee is notified by ACLA of the termination or pending termination, an Enrollee may continue an ongoing course of treatment with a non-participating Obstetrician (OB) or Midwife through the completion of post-partum care related to the delivery. Coverage for the continuation of an ongoing course of treatment will not be provided in the following circumstances:

   - The Practitioner/Provider contract was terminated by ACLA as the result of a professional review action (quality of care issue)

   - The Practitioner/Provider is unwilling to continue to treat the enrollee or accept ACLA's payment or other terms

6. Indian members who are enrolled and are eligible to receive services from an IHCP primary care provider participating as a network provider, and has the right to the following:

   - That IHCP as his or her PCP, as long as that provider has capacity to provide the services.
   - To obtain services covered under the contract from out-of-network providers where timely access to covered services cannot be ensured by ACLA.
   - An out-of-network IHCP is allowed to refer an Indian member to a network provider.

7. Behavioral Health:

- **ACLA shall collaborate with Office of Juvenile Justice (OJJ), Department of Children and Family Services (DCFS), and DOE to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;**
- **Collaborate with nursing facilities, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IIDs), hospitals, residential facilities and inpatient facilities to coordinate aftercare planning prior to discharge and transition of Enrollees for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;**
- **Collaborate with the Department of Corrections and local criminal justice systems in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services for Enrollees, including referral to community providers, prior to reentry into the community including, but not limited to, Enrollees in the Louisiana Medicaid Program pre-release program.**
- **Referrals shall be made for Enrollees to coordinate care with behavioral health and primary care providers and agencies that promote continuity of care.**

ACLA shall be responsible for the coordination and continuity of care of health care services for all Enrollees consistent with 42 CFR §438.208. In addition, ACLA shall be responsible for coordinating with LDH, including the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, to ensure integrated support across behavioral health services and long-term supports and services.

ACLA shall facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration include:

- **Mental illness and addiction are health care issues and shall be integrated into a comprehensive physical and behavioral health care system that includes primary care settings;**
- **As care is provided, both illness shall be understood, identified, and treated as primary conditions;**
- **The system of care shall be accessible and comprehensive, and shall fully integrate an array of prevention and treatment services for all age groups. It shall be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; and**
- **Relevant clinical information is accessible to both the primary care and behavioral health providers consistent with Federal and State laws, regulations, rules, policies, and other applicable standards of medical record confidentiality and the protection of patient privacy**

ACLA Enrollees receiving ongoing treatment, as outlined above, may not be billed for the costs of medically necessary core benefits and services.

ACLA associate may need to Use and/or Disclose a Member's Protected Health Information (PHI) for the purpose of Treatment, Payment or Health Care Operations (TPO). Federal HIPAA privacy regulations do not require Health Plans to obtain a Enrollee's written consent or Authorization prior to using, disclosing, or requesting PHI for purposes of TPO, therefore, ACLA is not required to seek a Enrollee's authorization to release their PHI for any one of the aforementioned purposes (see ACFC Policy #168.227, *General Policy – Use and Disclosure of Protected Health Information without Member Consent or Authorization*).

ACLA Associates may not Use, request or Disclose to others any PHI that is more than the Minimum Necessary to accomplish the purpose of the use, request, or disclose (with certain exceptions as outlined in ACFC Policy #168.217, *Minimum Necessary Standard*). ACLA Associates are required to comply with specific policies and procedures established to limit uses of, requests for, or disclosures of PHI to the minimum amount necessary.

ACLA will maintain adequate administrative, technical and physical safeguards to protect the privacy of PHI from unauthorized Use or Disclosure, whether intentional or unintentional, and from theft and unauthorized alteration. Safeguards will also be utilized to effectively reduce the likelihood of Use or Disclosure of PHI that is unintended and incidental to a Use or Disclosure in accordance with the PLAN policies and procedures (see ACFC Policy #168.213, *Guidelines to Safeguard Protected Health Information*). ACLA will reasonably safeguard PHI to limit incidental Uses and Disclosures. An incidental Use or Disclosure is a secondary Use or Disclosure that cannot reasonably be prevented, is limited in nature, and occurs as aby-product of an otherwise permitted Use or Disclosure (see ACFC Policy #168.213, *Guidelines to Safeguard Protected Health Information*).

ACLA Associates must follow facsimile guidelines in handling PHI that is transmitted or received in accordance with the company policy (see ACFC Policy #168.212, *Facsimile Machine and Transmission of Protected Health Information*).

~~ACLA shall be responsible for the coordination and continuity of care of health care services for all Enrollees consistent with 42 CFR §438.208. In addition, ACLA shall be responsible for coordinating with LDH, including the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, to ensure integrated support across behavioral~~

- ~~health services and long-term supports and services.~~

PURPOSE

To define a process whereby current member' medical needs are met during the transition of care between MCO's, redirection of care related to changes in provider contracting status and to define consistent processes for continuity of care for members new to ACLA.

DEFINITIONS

See ACLA Policy #UM.001L – Glossary of Terms
See ACFC Policy #168.235 – HIPAA and ACFC Privacy Definitions

PROCEDURE

A. New members with non-participating practitioners or providers

1. The UM staff will review the transition report from LDH monthly to determine if the Enrollee is transitioning from another MCO. Once identified as a transitioning Enrollee a request for information on all open prior authorizations will be sent to the relinquishing MCO. The UM staff will enter an authorization for a request for continuation of services meeting the above guidelines into the ACLA authorization system for the continuation of services time period outlined above. ACLA will in turn provide the medical information to an accepting MCO or Medicaid FFS upon request for Enrollees transitioning off the plan in the same manner.

   If a practitioner/provider identifies that an Enrollee has an authorization from Fee-for-Service medical assistance or another medical assistance managed care plan for durable medical equipment, prosthetics, orthotics and medical supplies, ACLA will honor the quantity and scope of services for thirty (30) calendar days from the member's effective date of enrollment with ACLA.

2. ACLA will not deny authorization solely on the basis that the practitioner/provider is not a participating ACLA practitioner/provider.

3. If ACLA is not the primary insurer for the member, the member may choose to stay with the terminated practitioner or provider.

4. All services from non-participating practitioners or providers after the initial thirty (30) days require prior authorization through utilization management. (See ACLA Policy #UM 153.904L – *Authorization for Out-of-Network Practitioners and Providers*) ACLA's authorization requirement may be waived if the primary insurance is Medicare.

B. Current Enrollees when a practitioner/provider terminating from the plan

1. When Provider Network Management staff become aware that a practitioner's/provider's contract is or will be terminated and continuity of care is available through this policy, an ad-hoc report is run to identify all Enrollees currently receiving services/products from the practitioner/provider whose contract is

terminating and the corresponding head of household, where applicable. For terminating PCPs, a panel report is run, listing all current active Enrollees and the corresponding head of household.

2. The Enrollee is notified by letter of the following information within fifteen (15) calendar days of the receipt of the termination notice from the provider:
   - The terminated practitioner/provider and the effective date of termination
   - The Enrollee's ability to continue services with the terminating practitioner/provider and how to access such services
   - For terminating PCPs, the letter also identifies the name, address and phone number of the new PCP assigned by the plan; a statement explaining the PCP assignment process; and notification that the Enrollee may select a different PCP by calling Enrollee Services within (10) business days of the postmark date of the termination of PCP notice to the Enrollee.
   - For terminating specialty practitioners, the letter contains a statement advising the Enrollee to contact their PCP to discuss any required ongoing medical needs, including transition to another participating specialist

3. If the plan is not the primary insurer for the Enrollee, the Enrollee may choose to stay with the terminated practitioner/provider. All care/services from nonparticipating practitioners or providers require prior authorization. (See ACLA Policy #UM.904L – Authorization for Out-of-Network Practitioners and Providers) ACLA's authorization requirement may be waived if the primary insurance is Medicare.
4. Emergency/Urgent care services do not require a prior authorization of services for participating or non-participating providers and is accessible for transitioning Enrollees.

REFERENCES (Cited Policies and Procedures and Source Documents)

RELATED POLICIES

- ACLA Policy #UM.001L, Glossary of Terms
- ACLA Policy #UM.904L, Authorization for Out-of-Network Practitioners and Providers
- ACLA Policy #168.212, Facsimile Machine and Transmission of Protected Health Information
- ACFC Policy #168.217, Minimum Necessary Rule
- ACFC Policy #168.213, Guidelines to Safeguard Protected Health Information
- ACFC Policy #168.227, General Policy – Use and Disclosure of Protected Health Information without Member Consent or Authorization

SOURCE DOCUMENTS AND REFERENCES

- MCO Standards and Guidelines (NCQA): Quality Improvement - Section 9(C)

ATTACHMENTS

None

REVIEW/REVISION DATES

Date	Type	Description of Revision
8/15/2011	Initial	This policy was created using the following policies to create a standard approach for the AmeriHealth Caritas Family of Companies: *153.706 – Continuity of Care*
11/14/2012	Yearly Review	
02/12/2013	Yearly Review-DHH Submission	
08/01/2014	Annual Review	Rebranding due to Name Change. Correction of grammatical errors. Change in policy numbering system. Update stakeholders
12/15/14	Contract Update	Information added to be compliant with new contract language
05/01/16	Annual Review	No change to scope or intent
03/01/2017	Annual Review	Purpose updated and information added to address the transition of members between MCO's.
01/23/2018	Contract update	Add contract verbiage. 12.18.1
02/19/2019	Annual Update	Updated for standardization; no change to scope or intent.
12/02/2019	Update with Emergency Contract	Section 6.38.1
02/4/2021	Annual Update	No change to policy scope or intent. Signature lines updated to reflect corporate leadership changes.
01/26/2022	Annual Update	ACFC Corporate Policy Numbers Updated
11/7/2022	Contract Update	Updated "member" to Enrollee Updated Contract reference sections Updated Policy #2 contract language: o Coordinating care with the relinquishing MCO so services are not interrupted o Arranging for continuity of necessary care by making referrals to appropriate providers of services that are in network

		Added following statement: "ACLA shall be responsible for the coordination and continuity of care of health care services for all Enrollees consistent with 42 CFR §438.208. In addition, ACLA shall be responsible for coordinating with LDH, including the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, to ensure integrated support across behavioral health services and long-term supports and services."

[-End of Policy-]

Policy and Procedure Approval
Policy and Procedure Type:

□ New □**X** Revision □ Review, No revision

□ Replacement (Replaced policy & procedure No._____)

Approval Signatures:

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