blue california
Promise Health Plan

POLICY & PROCEDURE
Medical Services

Policy Title: Continuity of Care on Termination of Provider/IPA/Hospital Benefits		
Policy No: 70.2.85	**Original Date: 9/99**	
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Department Head: Date:	**Medical Services/P&T Committee: Date:**	
P&P Committee: Date:	**Department(s): UM**	

PURPOSE:

To define and establish mechanisms for Blue Shield Promise Health Plan to provide the completion of covered services for members, upon contractual termination of a provider/IPA/hospital or benefits.

POLICY:

(A) General Policy:

a. Blue Shield Promise Health Plan shall provide members, the continuation of covered services by a terminated provider or by a nonparticipating provider, for conditions set forth in Health & Safety Code Section 1373.96(c) and described in detail below. Also, Blue Shield Promise Health Plan ensures that practitioners assist with a member's transition to other care, if necessary, when benefits end.

(B) Informing Enrollees/Members of this Policy

a. Blue Shield Promise shall provide to all new enrollees notice of its written continuity of care policy regarding the process for the member to request a review under this policy and the member's right to receive a copy of the policy upon request. This is done by including this information in the Member handbook, which is mailed to every new enrollee upon enrollment and annually thereafter. **Blue Shield Promise shall also make this policy available to enrollees within 48 hours of their request.**

(C) Training Member Services Representatives on this Policy

a. It is the responsibility of the Member Service Director to ensure that all Member Service Representatives are in-serviced with respect to new regulations, as they become effective. Please refer to Member Service Policy and Procedure 70.3.21 – Dept Training of New Legislation.

(D) Submitting an Enrollee Block Transfer Filing with DMHC

a. Blue Shield Promise Health Plan shall submit an "enrollee block transfer filing" to the Department of Managed Health Care (DMHC) at least 75 days prior to the termination of its contract with a provider group or hospital for approval. If DMHC does not respond within seven days of the date of its receipt of the filing, the notice shall be deemed approved.
b. Blue Shield Promise shall apply to DMHC for a waiver under exigent circumstances, which may prevent a 75-day filing and/or 60-day notice. If DMHC does not respond to such a waiver application within seven days of its receipt, the plan is deemed to have been granted the waiver applied for.

(E) Criteria for Assigning Enrollees/Members to Alternate Providers

a. Enrollees/Members are assigned to new providers through the use of specific criteria that meets DHS, LA Care, and DMHC standards that include:
    i. Family linkage;
    ii. Geographic proximity to the member;
    iii. Age, gender and language needs of the enrollees; DMHC geographic access standards; (28 CCR 1300.67.2, 1300.67.2.1 and Item H of 1300.51);
    iv. Verification of the receiving provider's capacity to accept and maintain the block of enrollees within the required provider-enrollee ratios; and
    v. Verification that the receiving provider has the administrative and financial capacity to accept and maintain the block of enrollees.
b. Process for reassignment of members at a Federally Qualified Health Center (FQHC) are coordinated as specified in Provider Network Operation Policy and Procedure 5.15.0 – FQHC PCP Termination & Member Reassignment.
c. Criteria for reassignment of members from a terminated hospital will include:
    i. DMHC's geographic access standards;
    ii. Verification that the receiving providers can admit to the alternate hospital; and
    iii. Verification that the alternate hospital has the same range of services as the terminated hospital.

(F) Notifying Enrollees/Members of Provider Termination and Re-assignment to an Alternate Provider

a. Blue Shield Promise Health Plan will provide 60 days notice of the contract's termination to enrollees assigned to the terminated provider as specified in enrollment Policy and Procedure 70.3.29 – Notification of Termination
    i. If the terminated provider is a hospital and the plan assigns enrollees to a provider group with exclusive admitting privileges to the hospital, the plan shall send the written notice to each enrollee who is a member of the provider group and who resides within a 15-miles radius of the terminated hospital.
    ii. Members assigned to a provider group with admitting privileges to hospitals in the same geographic area as the terminated hospitals will

receive written notices if they reside within a 15-mile radius of the terminated hospital.

iii. In all written, printed, or electronic termination communications sent to an enrollee that concern the contract termination or transfer, the following statement in not less than eight-point type must be included: "if you have been receiving care from a health care provider, you may have the right to keep your provider for a designated time period. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov"

b. Notification of re-assignment will be given to members only with letters pre-approved by LA Care, DHS, and MRMIB. (Refer to attachment 1A-1E – Member Letters). Each time an enrollee block transfer filing is submitted to DMHC copies of the appropriate member letter/s will be submitted for review and approval, prior to sending them out to affected enrollees.

c. If, after sending the notice to members, the health plan reaches an agreement with a terminated provider to renew or enter into a new contract, or to not terminate their contract, Blue Shield Promise Health Plan shall offer each affected enrollee the option to return, by mailing out a notice within 30 days of Blue Shield Promise reaching an agreement with a terminated provider or deciding not to terminate the contract if an affected enrollee does not exercise this option, Blue Shield Promise Health Plan shall reassign the enrollee to another provider based on criteria outlined above.

(G) Conditions Eligible for the Completion of Covered Services

a. The completion of covered services shall be provided by a terminated provider to a member who at the time of the contract's termination, was receiving services from that provider, or by a nonparticipating provider, to a newly covered member who, at the time the member became effective, was receiving from the provider for one of the conditions described below:

i. ***Acute Condition:*** a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem which requires prompt medical attention and which has a limited duration. Continuity of Care (CoC) is provided for the duration of the acute condition but shall not exceed twelve (12) months from the contract termination date.

ii. ***Chronic Condition:*** a medical condition, usually of slow progress and long continuance, and other than a Serious Chronic Condition, requiring ongoing care. Continuity of care is provided for the duration of the chronic condition but shall not exceed ninety (90) days from the contract termination date.

iii. ***Terminal Illness:*** an incurable or irreversible condition that has a high probability of causing death within one year or more. Completion of covered services shall be provided for the duration of the terminal illness.

iv. ***Serious Chronic Condition:*** a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Continuation of care is provided for the duration of the chronic condition but shall not exceed twelve (12) months from the contract termination date.

v. ***Pregnancy:*** continuation of care through the three trimesters of pregnancy and the immediate postpartum period

vi. ***Care of a newborn child:*** between birth and the age of 36 months. Continuation of care is provided for the duration of the chronic condition but shall not exceed twelve (12) months from the contract termination date.

vii. ***Performance of surgery or other procedure:*** that is authorized by the plan as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 calendar days of the contract's termination date.

viii. ***Mental health acute condition:*** a mental health condition that involves a sudden onset of symptoms that requires prompt mental health attention and that has limited duration. Transition period of 90 days or through the acute period illness, whichever is shorter, to continue course of treatment with the nonparticipating mental health specialist.

ix. ***Mental health serious chronic condition:*** a mental health condition that is serious in nature, and requires ongoing treatment to maintain remission or prevent deterioration. Transition period of 90 days or through the acute period of illness, whichever is shorter, to continue course of treatment with the nonparticipating mental health specialist.

(H) Enrollee/Member Requests for Continuation of Covered Services

a. Enrollees may file requests with Blue Shield Promise or a delegated PPG for continuation of covered services via facsimile, telephonically or by mail. Enrollee shall include the following information:
   i. Member name
   ii. Date of birth
   iii. Member ID#
   iv. Medical condition
   v. Service(s) requested
   vi. Treating provider's phone number and specialty
b. If member files the request with Blue Shield Promise, the request will be reviewed by the Blue Shield Promise Chief Medical Officer to determine whether the member's condition is consistent with conditions set forth in Section 1373.96(c).

Reasonable consideration shall be given to the potential clinical effect on an enrollee's treatment caused by a change of provider. Once the service is approved, the Blue Shield Promise Case Manager will coordinate the service(s) with the delegated PPG, the treating provider and the member to ensure that the member will receive continuity of care.

c. If Members files the request with the PPG, the request will be reviewed by the PPG Medical Director to determine whether the member's condition is consistent with conditions set forth in Section 1373.96(c). Reasonable consideration shall be given to the potential clinical effect on an enrollee's treatment caused by a change of provider. The PPGs are delegated for authorization and review process for the services that are specified in the contract between Blue Shield Promise and the PPG. These services shall include review and authorization of services under this policy. Blue Shield Promise Provider Network Operations shall inform PPGs of this additional delegated duty within 10 days of approval of this policy by DMHC.
d. Decisions on members requests under this policy shall be made within 5 working days for a non-urgent request and within 72 hours for an urgent request. (see "Definitions" section for the definition of an urgent request.)
e. If the member's request is denied by Blue Shield Promise or the delegated PPG, member will be notified in writing by Blue Shield Promise or the PPG. The denial letter shall comply with all DMHC and DHS requirements governing denial letters and shall include information on how to appeal the denial to Blue Shield Promise, LA Care, State Fair Hearing, and DMHC, as applicable.

(I) Contract and Compensation Arrangement with Providers

a. For terminated providers: Contract terms with contracted providers (primary care providers, specialists, ancillary care providers and hospitals) contracted directly by Blue Shield Promise, and with PPGs, require the provider or the PPG to continue to provide services to Blue Shield Promise members who are receiving services at the time of termination, who retain eligibility under the terms and conditions of a Benefits Agreement/Plan Contract, or by operation of law, until the services being rendered to the member are completed, at the compensation rates then in effect. Blue Shield Promise will also require the terminated provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.
b. If the contracted provider does not agree to comply with these terms and conditions, Blue Shield Promise/PPG is not obligated to continue the provider's services beyond the contract termination date.
c. For non-participating provider with whom there is no agreement between the Plan and the provider, the standard of payment shall be at rates and methods of payments similar to those used by the plan or provider group for currently contracting providers of similar services who are not capitated and in the same geographic area. Blue Shield Promise will also require the non participating

provider whose services are pursued under this policy to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracted similar non capitated providers in the same or similar geographic area including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

d. If the non participating provider does not accept such payment rates or does not agree to such terms and conditions, then the Blue Shield Promise/PPG is not required to continue the provider's services.
e. The amount of and requirements for co-payments, deductibles, or other cost sharing components during the completion of covered services with a terminated or non-participating provider, are the same as would be paid by the enrollee receiving care from a contracting provider.
f. Blue Shield Promise is not required to continue services of any provider(s) whose contract is terminated or not renewed due to medical disciplinary reasons.
g. Blue Shield Promise is not required to cover services that are not otherwise a covered benefit.
h. The UM Department will be responsible for locating a new provider for the member by utilizing the provider database and identifying providers who have the same qualifications, specialties, and facilities as the terminating provider and are within the appropriate mile radius of the member's home.

(J) Transition of Care when benefits end and member still needs care

a. When the member's coverage of services ends while a member still needs care, Blue Shield Promise Health Plan shall offer to educate and assist the member (or the member's designated representative) about alternatives for continuing care and how to obtain care, as appropriate.
b. Members whose benefits will end, but who will still need care, are identified from case manager reports, through the authorization referral process, or other processes such as reviewing member eligibility requirements for Linked and Carved-out Services.
c. Benefits ending may include, but are not limited to the following:
    i. Benefits ending due to benefit limitations, specific to the Member's Evidence of Coverage
    ii. Physical or occupational therapy
    iii. Behavioral Health Services
    iv. Durable Medical Equipment
    v. Home Health
    vi. Acute Rehabilitation Services
    vii. Long Term Care
    viii. Members reaching age 21 who are receiving CCS or other Linked and Carved-Out Services that have age specific requirements
    ix. Pregnant members whose pregnancy goes beyond member age specific eligibility requirements (such as reaching age 19 in HF before delivery) or other specific situations when coverage dues

d. Blue Shield Promise Health Plan assists eligible members to maintain continuity of care when accessing terminated provides when they meet the requirements identified above.
e. Blue Shield Promise Health Plan may grant continuation of treatment through the lesser of the current period of active treatment or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition. The suggested time frame will apply to Medicare product line. However, for Commercial/Medi-Cal lines of business timeframes may be granted for longer periods depending upon condition, for example, a pregnant woman with and EDC that may exceed 90 days.
f. Transition to other care:
    i. Any member receiving long term care for an acute or chronic condition is managed by a case manager.
    ii. The case manager will coordinate with the SNF case manager regarding members' medical coverage.
    iii. The case manger will notify the member in writing ahead of time when the member's benefit ends. The UM Department Case Managers will verify eligibility during the course of coordination of care with the SNF case manager.
    iv. The case manager will assist the member in identifying any additional community resources that may be available for continued medical care after benefits end.
        1. Blue Shield Promise Health Plan offers to educate the member about alternatives for continuing care as appropriate and informs the member of ways to obtain that care. For example, if a member's behavioral health benefits are exhausted and the member still needs treatment, the case manager will inform the member of alternative options for care that are available through a local or state funded agency.
        2. If a member's benefits for skilled nursing care are exhausted and the member still needs treatment, Blue Shield Promise Health Plan will inform the member of other custodial care options.
        3. For member with specific carve outs or other coverage such as dental, behavioral health and CCS, the case manager will provide this information, specific to the member, when available, in the letter to the member. For Healthy Families mental health services for members with severe emotional disturbances (SED) and severe mental illness (SMI) are carved out to the Department of Mental Health (DMH). Mental Health services for Medi-Cal members will be referred to the Department of Mental Health for L.A. County members and United Behavioral Health for San Diego County members.

g. UM Dept. will review all open encounters, referrals and denials related to the affected provider, on a daily basis to identify members who are in an active course of treatment, including:
   i. Approved referrals for elective surgery within the last 180 calendar days
   ii. Open and approved referrals within the last 180 calendar days
   iii. Inpatient admissions for patients currently in acute hospitals, skilled nursing facilities, and acute rehabilitation units.
   iv. Open referrals for prenatal and postpartum services, if applicable to the provider.

PROCEDURE:

1. When a Provider/IPA voluntarily or involuntarily ends its contract with Blue Shield Promise, it is the responsibility of the Provider Network Operations and COO to ensure that the Transfer Procedure is conducted as approved by DHS, MRMIB and LA Care. This policy pertains to direct contract providers as well as IPA contract providers.

2. The COO will ensure that an Enrollee Block Transfer Filing is submitted to DMHC 75 days prior to the termination for review and approval. This filing should include proposed member notification letters for DMHC approval.

3. Upon DMHC approval, it is the responsibility of the Member Service Director to ensure that the letters approved by LA Care, DHS, MRMIB and DMHC are sent to members within 60 days of termination notifying them of their right to remain with the same provider if they are receiving services as described in the policy above.

4. The Utilization Management (UM) Department will work with the terming Provider/IPA to obtain a list of members currently seeking care that qualifies as continuity of care.

5. Once the list is obtained from the terminating IPA, the Blue Shield Promise Case Manager will contact the member to inform him/her that based on the clinical condition, he/she shall continue to receive services from the terminated providers as long as the member retains eligibility, and for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultation with the member and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered member.

6. Members can also request for continuation of covered services by contacting Blue Shield Promise Member Services Department via facsimile, telephonically or mail.

7. Blue Shield Promise Member Services Department will forward the continuation of covered service request to the UM Department for approval.

8. The UM staff will submit the request to the Chief Medical Officer to verify that the member's condition is eligible for continuity of care under this policy. Upon approval by the CMO, the request will be forwarded to the Case Manager.

9. The Blue Shield Promise Case Manager will contact the treating provider to obtain minimum necessary clinical information for the approval process, i.e. member's current medical condition, a treatment plan, the initial treatment date and the anticipated completion date.

10. Once the information is obtained, the case will be forwarded to the Chief Medical Director for review.

11. A decision shall be made within 5 working days for a routine request, and 72 hours for an urgent request.

12. The decision will be communicated to the member and the treating provider in writing within 24 hours of the decision. If the request is denied, UM staff will send a denial letter to the member and the treating provider that complies with DHS and DMHC standards for denial letters. The denial letter shall also include information on member's appeal rights to Blue Shield Promise, LA Care, DHS and DMHC, as applicable.

13. If the provider is a non-participating provider and there is no agreement, the Director of Provider Network Operations will negotiate a fee schedule agreement with the non-participating provider to continue care. (Refer to attachment 2 – Fee schedule).

14. The UM Department will work closely with the member to obtain a new provider. The UM Department will assist to ensure that a provider with the same qualifications and specialties as the terminating provider or facility and ensure that the reassignment follows criteria set forth above in this policy.

15. Once a provider is chosen, the UM Department will contact that new provider and update him/her with the member's condition.

16. Blue Shield Promise will coordinate the exchange of the member's medical record information from the previous provider to the new provider when the enrollee's condition allows for such a transition.

17. The UM Department will monitor the care provided by requiring the provider to submit ongoing treatment plans, progress notes and other appropriate medical record information.

18. The Member Services department will ensure that the welcome packet mailing to every new enrollee contains information about this qualified benefit, how to request continuity of care, and how to obtain a copy of this policy.

19. Continuing Coverage of Services by a Non-Participating Provider for New Enrollees: Continuing medical services for newly enrolled L.A. Care Health Plan members who meet criteria to continue covered services with a non-participating provider. Covered Services are defined as the following medical conditions:

    a. **Acute Condition** means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
    b. **Serious Chronic Condition** means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
    c. **Pregnancy** means the three trimesters of pregnancy and the immediate postpartum period.
    d. **Terminal illness** means an incurable or irreversible condition that has a high probability of causing death within one year or more.
    e. **Care of a newborn** child between birth and age 36 months.
    f. **Performance of a surgery or other procedure** that has been authorized by the previous plan as part of documented course of treatment and has been recommended and documented by the Provider to occur within 180 days of the effective date of coverage for a newly eligible member.

20. With reasonable consideration given to the potential clinical effects on the members' treatment caused by a change in provider, Plan shall identify members that may require continuation of services (e.g., pending surgeries, inpatient admissions, pregnancies, consultations, and ongoing treatments/procedures, durable medical equipment, prosthetic, orthotics and medical supplies).
21. This is accomplished by reviewing appropriate medical records, in collaboration with the Plan physician advisor, the PPG, and the treating provider.

DEFINITIONS:
All section references are to the California Health & Safety Code.

Individual Provider means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business & professions Code.

Member means an enrollee who has elected, or has been assigned to, Blue Shield Promise Health Plan to receive health care services under a contract between Blue Shield Promise Health Plan and LA Care, DHS or MRMIB. The terms member and enrollee are use synonymously in this Policy.

Provider means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services (1345 (i)) The term Provider includes both an Individual Provider and a hospital.

Provider Group means a medical group, independent practice association, or any other similar organization 1373.96(k)(4)

Non-participating provider (non-contracted provider) means a provider who is not contracted with Blue Shield Promise Health Plan or a Provider Group contracted with Blue Shield Promise Health Plan.

Terminating provider means a provider whose contract with Blue Shield Promise Health Plan or a Provider Group contracted with Blue Shield Promise Health Plan, to provide services to Blue Shield Promise enrollees is terminated or not renewed upon the expiry of the term of the contract.

PPG (Participating Provider Group) means a Provider Group that is contracted with Blue Shield Promise Health Plan to provide or arrange for the provision of health care services.

Urgent Request is when the member's condition is such that the member faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to member's life or health or could jeopardize the member's ability to regain maximum function.

REFERENCES/AUTHORITIES: