Continuity of Care FAQs and Answers Document

February 2022

Note: this document is a high-level overview of complex legislation. An appendix is included with expanded EOB language.

Overview of changes to CoC

Federal

Continuity of Care (CoC) is addressed in Section 113 of the 2020 Consolidated Appropriations Act (CAA) and is meant to ensure continuation of care for patients in the middle of complex care in the case when their provider's contract is terminated.* The CAA creates federal CoC laws, whereas previously only state CoC laws existed.

Under federal law, continuing care patients can stay with a terminated provider* if receiving treatment for pregnancy, a serious and complex condition, or a terminal illness. Inpatients and individuals scheduled for non-elective surgery may also stay with a terminated provider.

Providers must continue care until treatment ends or 90 days after notice of termination is received, whichever is sooner. They must accept payment, follow policies and procedures, and meet quality standards as if the expired contract were still in place.

California

Federal requirements for continuity of care, which are stricter than California's, must be incorporated into self-funded plans. California employers are not mandated to provide state CoC completion of covered services for self-funded groups. Blue Shield offers Self-Funded Employer Groups to enroll in both state and federal mandate as part a commitment to providing flexibility and customization for self-funded clients.

Self-Funded Employers† may elect to offer both Federal benefits and California state benefits for completion of covered services. Self-funded groups can elect to include state mandates for a variety of reasons. The company may offer a fully-insured product (like an HMO) alongside the self-funded PPO and would like parity for their membership, or some employers are newly moving off a full-insured plan and choose to mirror the previous offerings to avoid member abrasion.

* Unless the provider is terminated for reasons other than fraud or failure to meet quality standards.
† Continuity of care is not optional for employer groups regulated by Department of Managed Health Care (DMHC) and California Department of Insurance (CD) as they regulate health care services plans and insurers and neither agency regulates employer groups.

What kinds of Market Segments are impacted?

In scope: IFP, Small Business, Large Group On and Off Exchange; Self-Funded and Joint Administered Group plans.

Out of Scope: Dental, Vision, or Life insurance plans. CAA does not impact Medicare, including Medicare Supplement plans, Medi-Cal (Medicaid), or Medicaid-Medicare plans (MMPs/ CMC (BSC Promise CMC)).

Who is qualified to enroll in federal CoC benefits? How will a member know if they qualify?

If a member's provider is no longer available, Blue Shield or their Mental Health Service Administrator (MHSA) will notify the member of the option to continue treatment with the member's former Participating Provider. A member can request continuity of care by visiting blueshieldca.com and fill out the Continuity of Care Application.

An enrollee qualifies as an eligible individual for Continuity of Care if he or she is receiving care from a network provider for a/an:

a. Acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
b. Chronic illness or condition that is (i) life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.
c. Course of institutional or inpatient care from a provider.
d. Nonelective surgery from the provider, including receipt of post-operative care with respect to a surgery.
e. Pregnancy and is undergoing a course of treatment for the pregnancy, or
f. Terminal illness and is receiving treatment for such illness from a provider.

What was the go-live date?

The federal CoC benefits mentioned here are effective for plan years beginning on or after January 1, 2022. This means federal CoC laws were effective for new group plans and for individual and family plans (IFP) on January 1, 2022, and for renewing group plans upon renewal, on or after January 1, 2022.

How can a past claim be rectified once CoC is approved?

A member requests adjustment through Customer Service. Customer Service will route adjustment request to claims for processing.

How will claims be paid? How does a member pay the claim as per previous contract rate?

Claims will process based on UM Level of Care notes regarding pricing. Claims are processed at the in-network benefit. The DLP instructs the processor to pay at in-network benefit and pay provider. Pricing is not needed unless mentioned in the UM notes.

What are the claims DLP that oversee this process?

Two DLPs are available via links – a WFWM document and a RTCP document.

What are the qualifying scenarios for CoC?

1. Provider terminates from the network.
2. Employer Groups terminate their BSC plans.
3. Employer Groups change network offerings.

Does BSC offer Federal CoC for Newly onboarded Groups?

No. Federal CoC is only offered at group Termination, for qualifying medical conditions.

What CoC Benefit options are currently offered for Self-Funded Groups?

1. Federal CoC.
2. Federal + State CoC.
3. Opting out of BSC administering CoC.

What are the member notification requirements that changed with the Federal CoC mandate?

BSC sends a member notice upon the occurrence of the below scenarios:

1. Provider termination.
2. Group Termination.
3. Group plan changes (Movement from PPO to Tandem or PPO to HMO etc.).

What happens when a provider group terminates its contract with the plan altogether?

When a contracted provider group terminates from BSC's network, BSC will send a member notification to applicable members. The notification informs the member of potential CoC eligibility so they can continue seeing the terminated provider. The member can apply for CoC if they think they are eligible. Once approved, we will notify both the member and the provider. CoC will then need to be allowed for up to 90 days or until the treatment concludes, whichever is sooner.

Does the federal CoC Mandate apply to delegated medical groups?

The Federal CoC Mandate applies to Blue Shield as a Health Care Service Plan, an Issuer, and as a TPA when a participating provider leaves the network. This also apples to Blue Shield's Mental Health Service Provider (MHSA), Magellan (fully-insured only) and to delegated medical groups and IPAs.

Appendix

Continuity of care may be available if:

- A member's participating Provider becomes a Non-Participating Provider during care;
- A member's Mental Health Service Administrator (MHSA) Participating Provider becomes an MHSA Non-Participating Provider during care;
- Blue Shield or the MHSA no longer contracts with a member's former Participating Provider for the services the member is receiving; or
- The member is a newly-covered member whose previous health plan was withdrawn from the market.

Continuity of care may also be available when a member's Employer terminates its contract with Blue Shield and contracts with a new health plan (insurer) that does not include the member's Blue Shield Participating Provider in its network.

If a member's former Participating Provider is no longer available to the member for one of the reasons noted above, Blue Shield or the MHSA will notify the member of the option to continue treatment with the member's former Participating Provider. A member can request to continue treatment with a member's Non-Participating Provider in the situations described above if the member is currently receiving the following care:

- Ongoing treatment for an acute or serious chronic condition;
- Ongoing institutional or inpatient care;
- Pregnancy care, including care immediately after giving birth;
- Treatment for a maternal mental health condition;
- Treatment for a terminal illness;
- Other services authorized by Blue Shield or the MHSA as part of a documented course of treatment, including a scheduled non-elective surgery or procedure; or
- Ongoing treatment for a child up to 36 months old.

To request continuity of care, members should visit blueshieldca.com and fill out the Continuity of Care Application. Blue Shield will confirm the member's eligibility and may review the request for Medical Necessity.

The Non-Participating Provider must accept Blue Shield's or the MHSA's Allowable Amount as payment in full for a member's ongoing care. Once the provider accepts and the member's request is authorized, the member may continue to see the Non-Participating Provider at the Participating Provider Cost.