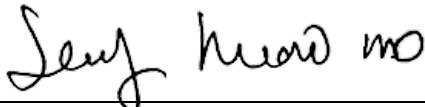
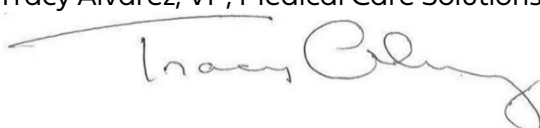


Policy Title: Medical Exemption Requests (MERs) for Continuity of Care		POLICY #: 10.02.24	
		Line of business: Medi-Cal	
Department Name: Utilization Management	Original Date: 5/15	Effective Date: 5/19	Revision Date: 9/24
Governing Committee: Medical Services Committee			
Governing Committee Approval: Jennifer Nuovo, MD, Blue Shield Promise Chief Medical Officer 		Date: 9/9/24	
Vice President (VP) Approval: Tracy Alvarez, VP, Medical Care Solutions 		Date: 9/9/24	

A. PURPOSE

To define and establish mechanisms for Blue Shield of California Promise Health Plan (Blue Shield Promise) in accordance with All Plan Letter (APL) 17-007 and California Health & Safety (H&S) Code Section 1373.96 to ensure appropriate continuity of care (CoC) for members of Blue Shield Promise who transition from Fee-For-Service (FFS) Medi-Cal into Medi-Cal managed care plan (MCP) who are included on the Exemption Transition Data Report, and who have (1) submitted a Medical Exemption Request (MER), and/or Emergency Disenrollment Exemption Request (EDER), and/or (2) who have been revoked an approved exemption by the Department of Health Care Services (DHCS). If such members have been denied or have a revoked MER, they may still be entitled to CoC per guidelines with APL 17-007 and H&S Code Section 1373.96. This policy only applies to the Medi-Cal subpopulation that has undergone a medical exemption request.

B. DEFINITIONS

1. "Acute Condition" – 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.
2. "Continuity of Care" – the lack of interruption in needed care as it pertains to APL 17-007 and H&S Code 1373.96.

3. "Exemption Transition Data Report" – a report posted to the Secure Data Exchange Services (SDES) website on a weekly basis that identifies members who received a MER denial in the past 45 days who will subsequently or already has transitioned to an MCP. This data file contains information for both pending and active members and uses the most recent choice/default information on record. This data file is accessible at <http://healthcareoptions.maximus.com/sdes/>
4. "Existing Relationship" – is present when a member has seen an out-of-network primary care or a specialty care provider at least once for a non-emergency visit during the 12 months prior to the initial enrollment date into Blue Shield Promise Health Plan.
5. "Medical Exemption Request" – a member who has been granted a medical exemption from Blue Shield Promise Health Plan enrollment may remain with FFS provider until his or her condition has stabilized to a level that would enable him or her to change to a Blue Shield Promise physician without deleterious medical effects, as determined by the member's FFS Medi-Cal provider. At any time during the exemption verification process, DHCS may verify the complexity, validity, and status of the member's medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with Blue Shield Promise in the member's county of residence.
6. "Newborn" – a child between birth and 36 months of age.
7. "Non-participating Provider (Non-contracted Provider)" – a provider who is not contracted with Blue Shield of California Promise Health Plan or a Provider Group contracted with Blue Shield of California Promise Health Plan.
8. "Pregnancy" and "postpartum care"– the three trimesters of pregnancy and the immediate postpartum period of 12 months; includes maternal mental health.
9. "Provider Group" – a Medical Group, an Independent Physician Association (IPA), or any other similar organization.
10. "Risk of Harm" – an imminent and serious threat to the health of the member.
11. "Serious Chronic Condition" – 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.
12. "Specialist" – a physician or other health professional who has advanced education and training in a clinical area of practice and is accredited, certified or recognized by a board of physicians or like peer group, or an organization

offering qualifying examinations (board-certified) as having special expertise in that clinical area of practice.

13. "Terminal illness" – an incurable or irreversible condition that has a high probability of causing death within one year or less.
14. "Terminated Provider" - 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 members is terminated or not renewed upon the expiration of the term of the contract.

C. POLICY

- I. Blue Shield Promise will treat every exemption listed on the Exemption Transition Data report as an automatic continuity of care request for the identified member and make every effort to ensure that the member is allowed to continue receipt of ongoing medical care through his or her FFS or nonparticipating health plan provider(s) for such stated periods of time specified in H&S Code Section 1373.96. Blue Shield Promise will provide the completion of covered services that are being provided by a contractually terminated or out of network provider, in accordance with the continuity of care requirements set forth in H&S Code Section 1373.96 and APL 17-007.
- II. The completion of covered services will continue to be provided by a terminated provider to an member who at the time of the contract's termination, was receiving services from that provider for one of the conditions eligible for completion of covered services, as listed in this policy.
- III. Blue Shield Promise will consider a request for exemption from its health care plan enrollment that is denied as a request to complete a course of treatment with an existing FFS or nonparticipating health plan provider under H&S Code 1373.96 and in compliance with Blue Shield Promise's contract with DHCS and any other DHCS continuity of care APLs.
- IV. Blue Shield Promise will adhere to time frames that are listed in H&S Code Section 1373.96, DHCS APL 23-022, or any superseding APLs.
- V. The member's existing provider is identified by the National Provider Identifier on the MER.
- VI. This policy is additional to the extended continuity of care policy for Seniors and Persons with Disabilities established under APL 11- 019, APL 23-022 on continuity of care for

members who transition into managed care, and other continuity of care APLs. See UM Policy 10.2.40 Continuity of Care for Medi-Cal Members.

- VII. DHCS may deny a request for exemption from Blue Shield Promise enrollment or revoke an approved exemption if a provider fails to fully cooperate with DHCS's verification process.
- VIII. Populations affected by this policy:
 - a. Members who have the following conditions:
 - i. Acute condition
 - ii. Serious chronic condition
 - iii. Pregnancy, including a person who presents written documentation of being diagnosed with a maternal mental health condition
 - iv. Terminal illness
 - v. Care of a newborn child between birth and age 36 months
 - vi. Surgeries or other procedures that were previously authorized as a part of a documented course of treatment
 - b. Members who have been granted a medical exemption from enrollment. Such members may remain with the FFS provider until his or her medical condition has stabilized to a level that would enable him or her to change to a physician without deleterious medical effects, as determined by the member's FFS provider.
 - c. Newly enrolled managed care members in need of continued use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by Blue Shield Promise, until the prescribed therapy is no longer prescribed by the contracted provider.
 - d. For members under 21 years of age with a diagnosis of autism spectrum disorder (ASD) transitioning from a Regional Center, or other diagnosis for which behavioral health treatment (BHT) has been identified as medically necessary, a continuity of care request will be generated prior to the member's transition from BHT services. Blue Shield Promise will follow guidelines for this population's continuity of care as outlined in APL 23-010 and subsequent APLs.

D. PROCEDURES

- I. Organizational Process
 - a. Blue Shield Promise utilization management (UM) staff will access the Exemption Transition Data Report on a weekly basis using the same schedule as the Weekly Plan File (WPF) on the SDES's website, <http://healthcareoptions.maximus.com/sdes/>
 - i. For members who are pending and not yet active, MCPs will use the data provided in the WPF to contact the members and initiate the continuity of care process.
 - b. Upon receipt of MERs data from LA Care or DHCS, Blue Shield Promise UM staff will automatically initiate member outreach.
 - c. Blue Shield Promise UM staff will make three attempts to contact the member inclusive of one letter and two phone calls.
 - i. If on the second call attempt, the member is still unreachable and all outreach attempts have failed, a generalized voice message should be left explaining how the member can contact Blue Shield Promise.
 - ii. If the member is contacted, appropriate CoC will be initiated, and the CoC process will commence within five working days from the receipt of their request. In this case, receipt of the Exemption Transition Data report constitutes such a request.
 - d. If the member chooses to change MCPs, the completion of covered services shall be continued by the new MCP for a period of up to 12 months from the date of enrollment with Blue Shield Promise.
 - e. Blue Shield Promise will provide information to members about their CoC rights as well as providers (in and out of network) about the requirements set forth for CoC with MERs. Blue Shield Promise will supply this information in provider training and new member orientation materials.
 - f. Blue Shield Promise will oversee and remain accountable for CoC guidelines even in such circumstances that independent physician's association, medical group, or entity is subcontracted for care.
 - g. Blue Shield Promise UM staff will make any and all good faith efforts to establish a contract, Letter of Agreement (LOA), or single-case agreement in the event that the member's FFS or nonparticipating health plan provider is not in-network.
 - h. Blue Shield Promise UM staff will assess and identify members who have had a MER denied in the past 45 days and make initial outreach activity to preserve continuity of care.

- II. Completion Considerations of a Continuity of Care Request:
 - a. A continuity of care request is considered completed when:
 - i. The member is informed of his or her right of continued access or if Blue Shield Promise and the out-of-network FFS provider are unable to agree on a rate;
 - ii. Blue Shield Promise has documented quality of care issues; or
 - iii. Blue Shield Promise makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.
 - b. ~~At the discretion of Blue Shield Promise UM staff, the continuity of care period~~

may be upheld with the member's out-of-network provider beyond the standardized continuity care period of 12 months.

- c. Blue Shield Promise UM will complete its response to each MER request within:
 - i. Thirty (30) calendar days from the initial date of receipt, or;
 - ii. Fifteen (15) calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
 - iii. Three (3) calendar days if there is a present risk of harm to the member.
 - 1. For any circumstance that has been requested as a risk for harm and appears unclear to the UM staff member, as it pertains to risk for harm, the request will be reviewed by a physician.
 - 2. Only a physician will determine if risk for harm does not apply.
- III. Processing Member Requests for Continuation of Covered Services:
- a. Members, their authorized representatives on file with their provider plan, or their provider, may make a direct request for continuity of care. Members may file requests through Blue Shield Promise for continuation of covered services via facsimile, telephonically, or by mail.
 - i. Blue Shield Promise will accept requests for continuity of care over the telephone, according to the requester's preference, and will not require that the requester complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, Blue Shield Promise will take any necessary information from the requester over the telephone.
 - b. The Member will provide the following information:
 - i. Member Name
 - ii. Date of Birth
 - iii. Member ID#
 - iv. Telephone number
 - v. Medical condition
 - vi. Services requested
 - vii. Treating provider's address, phone and specialty
 - c. UM staff will document the medical exemption request in MHK database.
- IV. Terms and Conditions with Non-Participating Provider:
- a. Blue Shield Promise may require a non-participating provider whose services are continued for a newly covered member to agree in writing to be subject to credentialing, utilization review, peer review, and quality improvement requirements.
 - b. If the non-participating provider does not agree to comply or does not comply with these contractual terms and conditions, Blue Shield Promise is not required to continue the provider's services.
 - c. Unless otherwise agreed upon by the non-participating provider and Blue Shield Promise Health Plan, the services rendered will be compensated at fee-for-

service rate.

- d. Neither Blue Shield Promise Health Plan nor the provider group is required to continue the services of a non-participating provider if the provider does not accept the payment rates provided for in this section.
 - e. Blue Shield Promise Health Plan shall provide members access to an out-of-network provider for up to 12 months if:
 - i. The member has an ongoing, prior relationship with the provider that can be documented using fee-for-service claims data;
 - ii. The provider accepts fee-for-service rates or the same rates and methods of payment as those used by Blue Shield Promise Health Plan for currently contracting providers providing similar services and who are practicing in the same or a similar geographic area as the terminated provider, AND;
 - iii. The provider has no quality of care issues and meets all credentialing requirements.
- V. Assessing the Terminated/Non-Participating Provider for Credentialing Qualification:
- a. The Blue Shield Promise Credentialing Department will notify the UM Department for the approval of the terminated or non-participating provider using the Credentialing Check Form (CCF).
 - b. If the requested terminated or non-participating provider meets the credentialing criteria, the UM staff will forward the LOA Request via the LOA database to Provider Network Operations (PNO) to offer a one-time letter of agreement, or other form of relationship to establish a continuity of care relationship for the member.
 - c. Refer to section D(II) for Completion Timelines.
- VI. Medical Exemption Review Process of a Terminated/Non-Participating Provider
- a. If the credentialing criteria are not met, the completed CCF will be forwarded by the Credentialing Department to the Blue Shield Promise Chief Medical Officer or physician designee for review.
 - i. If not approved, the requested terminated or non-participating provider and the member will be notified by the UM Department and an alternate provider will be assigned.
 - b. The UM Department will assess the request to:
 - i. Determine whether the member's condition is consistent with conditions set forth in Section 1373.96 (c), conditions eligible for covered services (may be subject to MD review);
 - ii. Determine whether the member's condition is consistent with conditions or circumstances are set forth in APL 17-007;
 - iii. Determine prior relationship with the requested provider through review of claims data from the State;
 - iv. Active FFS Treatment Authorization Requests (TARs).
 - c. If the above are established, and the provider meets criteria and agrees to accept

the higher of Blue Shield Promise rates or FFS rates, Blue Shield Promise UM will offer a letter of agreement for:

- i. Conditions and Timeframes for Completion of eligible covered services, as set forth in Section 1373.96.
 - ii. Conditions and Timeframes for Completion of eligible covered services, as set forth in APL 17-007.
- d. Blue Shield Promise UM will work with the provider in establishing a treatment plan for the member.
- i. The treatment plan will be utilized through the continuum of the member's treatment and as appropriate when the member is transitioning at the end of the authorized treatment time frame or to an in-network provider.
- e. If the provider refuses the rate, the member will be notified verbally and assisted by a Blue Shield Promise UM representative to continue care with an in-network provider who is qualified to evaluate and treat the member's condition.
- i. The member will have the option to select a contracted in-network provider of his or her choice.
- f. UM staff will document CoC request outcomes in the member file.
- g. UM staff will notify the member of the decision following the customary process of authorization determinations and notifications as they apply to requirements.
- i. In the case of an adverse determination and the member disagrees with Blue Shield Promise, the member can:
 1. File a grievance or Appeal;
 2. Request a Medical Exemption from DHCS, assuming the request is within the first 90 days of enrollment in Blue Shield Promise.
- h. Other elements within the notification process will include the following:
- i. The services approved;
 - ii. The duration of the COC arrangement;
 - iii. The process that will occur to transition the member's care at the end of the continuity care period.
 1. This will include informing the member that 30 days before the CoC ends, he/she will be contacted by a Blue Shield Promise representative to assist the member.
 2. The member's right to choose a different provider from the Plan's network.
 3. A list of contracted providers in the network will be provided for the member to select from.
- VII. Member Education and Outreach Process
- a. Members will be informed of CoC provisions through:
 - i. Enrollment materials

- ii. Member Handbook
 - iii. Welcome Calls
 - iv. Health Risk Assessment (HRA) process
 - v. Member Services outreach activities
- b. Education materials will include the availability of CoC materials in threshold languages and other alternative formats at the request of the member.

VIII. Considerations for Timeframes, Payments, and Exclusions

a. Conditions and Timeframes for completion of eligible covered services, as set forth in H&S Code section 1373.96(c) and APL 23-022:

- i. Acute condition: Blue Shield Promise will provide for the completion of covered services for the duration of the acute condition.
- ii. Serious chronic condition: Blue Shield Promise will provide for the completion of covered services for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Blue Shield Promise, in consultation with the member and the terminated provider or non-participating provider and consistent with good professional practice. Completion of covered services will not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered member.
- iii. Pregnancy and postpartum care: Blue Shield Promise will provide for the completion of covered services for the duration of the pregnancy and immediate postpartum period of 12 months. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition will not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
- iv. Terminal illness: Blue Shield Promise will provide for the completion of covered services for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new member.
- v. Care of a newborn child between birth and age 36 months: Blue Shield Promise will provide for the completion of covered services will not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered member.
- vi. Performance of a surgery or other procedure that is authorized by Blue Shield Promise as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered

member: Blue Shield Promise will provide for the completion of covered services within 180 days of the termination date or effective date of coverage.

IX. Exclusions and Quality Concerns:

- a. Blue Shield Promise Health Plan is not required to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, or fraud or other criminal activity.
- b. Blue Shield Promise Health Plan is not required to cover services or provide benefits that are not otherwise covered or the terms and conditions of Blue Shield Promise Health Plan's contract.
- c. This section shall not apply to a newly covered member who is offered an out-of-network option or to a newly covered member who had an option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

X. Delegated Oversight

- a. Blue Shield Promise Health Plan shall ensure the delegates meet the requirements of HSC Section 1373.96 and APL 18-008.
- b. Providers and Delegates will be educated on COC provisions through:
 - i. Webinars
 - ii. Dissemination of Blue Shield Promise COC policy
 - iii. Provider Manual updates
 - iv. Individual Group onsite trainings
- c. Delegated IPAs are bound to follow the requirement of COC in accordance with APL 17-007 provisions. IPAs educated by Blue Shield Promise Health Plan to use same approved letters and processes. Compliance will be monitored through reporting. The IPAs will be required to submit pre-established periodic reports to the Plan of all COC activities to include:
 - i. Timeframes for processing
 - ii. Copies of Organization Determination Notices
 - iii. Transition activities

XI. MONITORING

N/A

XII. REPORTING

- a. Exemption Transition Data Report:
 - i. DHCS provides a data file to notify MCPs of beneficiaries who received a MER denial in the past 45 days who have or will transition into an MCP. The Exemption Transition Data report is accessible on the Secure Data Exchange Services (SDES) website for California Health Care Options: <http://healthcareoptions.maximus.com/sdes/>.
 - ii. After reviewing the Exemption Transition Data File, Blue Shield Promise will submit any questions to MAXIMUS at: cahcohelpdesk@maximus.com, using "MER/EDER Data File" in the

subject line of the email.

- b. Monthly MER Denial Report (MMDR) Reporting Requirements:
 - i. Blue Shield Promise Utilization Management will submit a Monthly MER Denial Report (MMDR) to LA Care or DHCS using the instructions and report template that are provided with APL 17-007 as Attachment B.
 - ii. Blue Shield Promise will submit the MMDR to LA Care or DHCS Secure File Transfer Protocol (SFTP) site: <https://etransfer.dhcs.ca.gov> by the 15th day of the second month following the reporting period.

XIII. ATTACHMENTS

Attachment A, APL 17-007	Exemption Transition Data Report File Format
Attachment B, APL 17-007	Monthly MER Denial Report (MDR) Template

XIV. REFERENCES

1. California Health & Safety Code, Section 1373.96
2. Welfare and Institutions Code, Section 14185(b)
3. APL 11-019: Extended Continuity of Care for Seniors and Persons with Disabilities
4. APL 17-007: Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption and Implementation of Monthly Medical Exemption Review Denial Reporting
5. APL 23-010: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
6. APL 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, On or After January 1, 2023
7. APL 23-010: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
8. UM P&P 10.2.40 Continuity of Care for Medi-Cal Members

XV. REVISION HISTORY

Date	Modification (Reviewed and/or revised)	E-filing Number
9/24	2024 Annual Review <ul style="list-style-type: none">• Updated references/reviewed regulatory requirements• Added attachments	
10/23	2023 Annual Review	