blue california
Promise Health Plan

Policy Title: Medical Exemption Requests (MERs) for Continuity of Care		POLICY #: 10.2.24 Line of business: Medi-Cal	
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Department Head:		**Date: 10/22**	
Medical Services/P&T Committee: (If Applicable)		**Date: 10/22**	

PURPOSE

To define and establish mechanisms for Blue Shield of California Promise Health Plan (Blue Shield Promise) in accordance with APL-17-007 and Health & Safety Code Section 1373.96 to ensure appropriate continuity of care (COC) for beneficiaries of Blue Shield Promise Health Plan 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a Medical Exemption Request (MER), and/or Emergency Disenrollment Exemption Request (EDER), and/or (2) who have been revoked an approved exemption by DHCS. If such beneficiaries have been denied or has a revoked MER, they may still be entitled to COC per guidelines with APL 17-007 and Health & Safety Code Section 1373.96. This policy only applies to the Medi-Cal sub population that has undergone a medical exemption request.

POPULATIONS AFFECTED BY THIS POLICY

1. Beneficiaries who have the following conditions:
    a. Acute condition
    b. Serious chronic condition
    c. Pregnancy; including a person who presents written documentation of being diagnosed with a maternal mental health condition
    d. Terminal illness
    e. Care of a newborn child between birth and age 36 months
    f. Surgeries or other procedures that were previously authorized as a part of a documented course of treatment

2. Beneficiary who has been granted a medical exemption from enrollment. Such beneficiaries 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 beneficiary's FFS provider.

3. Newly enrolled managed care beneficiaries 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 beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by the Blue Shield Promise Health Plan, until the prescribed therapy is no longer prescribed by the contracted provider.

4. For beneficiaries under 21 years of age with a diagnosis of ASD transitioning from a Regional Center, or other diagnosis for which BHT has been identified as medically necessary, a continuity of care request will be generated prior to the beneficiary's transition from BHT services. Blue Shield Promise will follow guidelines for this population continuity of care as outlined in APL-18-006 and subsequent APLs.

POLICY

Blue Shield Promise Health Plan shall treat every exemption listed on the Exemption Transition Data report as an automatic continuity of care request for the identified beneficiary, and make every effort to ensure that the beneficiary 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 Safety Code Section 1373.96. Blue Shield Promise shall 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 Health & Safety Code Section 1373.96 and APL-17-007.

The completion of covered services shall continue to be provided by a terminated provider to an enrollee 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.

Blue Shield Promise shall consider a request for exemption from its health care plan enrollment that is denied as a request to complete a course or 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 APL. Blue Shield Promise will adhere to time frames that are listed in Health & Safety Code Section 1373.96.

The beneficiary's existing provider is identified by the National Provider Identifier on the MER.

Such said continuity of care policy is additional to the extended continuity of care policy for Seniors and Persons with Disabilities established under APL 11-019, Duals Plan Letter (DPL) 16-002 on continuity of care, APL 18-008 on continuity of care for beneficiaries who transition into managed care, and other continuity of care APLs and DPLs.

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.

DEFINITIONS:

Continuity of Care can be defined as the lack of interruption in needed care as it pertains to APL17-007 and H&S Code 1373.96**.**

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.

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.

Pregnancy – the three trimesters of pregnancy and the immediate post-partum period; including maternal mental health.

Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less.

Newborn – child between birth and 36 months.

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.

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 enrollees is terminated or not renewed upon the expiration of the term of the contract.

Provider Group – a Medical Group, an IPA, or any other similar organization.

Risk of Harm - is defined as an imminent and serious threat to the health of the beneficiary.

Existing Relationship means 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.

Specialist means 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.

Medical Exemption Request a beneficiary who has been granted a medical exemption from Blue Shield Promise Health Plan enrollment that 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 beneficiary's FFS Medi-Cal provider. At any time during the exemption verification process, DHCS may verify the complexity, validity, and status of the beneficiary's medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with Blue Shield Promise in the beneficiary's county of residence.

Exemption Transition Data Report is a report posted to SDES on a weekly basis that identifies beneficiaries 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 beneficiaries and uses the most recent choice/default information on record. This data file is accessible at http://healthcareoptions.maximus.com/sdes/

PROCEDURE

I. Organizational Process

1. Blue Shield Promise UM staff can 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/

    a. For beneficiaries who are pending and not yet active, MCPs should use the data provided in the WPF to contact the beneficiaries and initiate the continuity of care process.

2. Upon receipt of MERs data from LA Care or DHCS, Blue Shield Promise UM staff will automatically initiate beneficiary outreach.

3. Blue Shield Promise UM Staff will make three attempts to contact the beneficiary inclusive of one letter and two phone calls.

4. If on the second call attempt, the beneficiary is still unreachable and all outreach attempts are proven failed, a generalized voice message should be left explaining how the beneficiary can contact Blue Shield Promise.

5. If the beneficiary is contacted, appropriate COC will be initiated and the COC process commences within five workings days from the receipt of their request. In this case, receipt of the Exemption Transition Data report constitutes such a request.

6. If the beneficiary 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.

7. Blue Shield Promise will provide information to beneficiaries 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.

8. 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.

9. Blue Shield Promise 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 beneficiary's FFS or nonparticipating health plan provider is not in-network.

10. Blue Shield Promise will assess and identify beneficiaries 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:

1. The beneficiary 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.

2. Blue Shield Promise has documented quality of care issues; or

3. Blue Shield Promise makes a good faith effort to contact the provider and the provider is unresponsive for 30 calendar days.

4. At the discretion of Blue Shield Promise, the continuity of care period may be upheld with the beneficiary's out-of-network provider beyond the standardize continuity care period of 12 months.

5. Blue Shield Promise MER Completion Timelines:
   - Blue Shield Promise will complete its response to each MER request within 30 calendar days from the initial date of receipt, or ;
   - Within 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs.
   - Blue Shield Promise will complete MER requests within 3 days if there is a present risk of harm to the beneficiary.
     i. For any circumstance that has been requested as a risk for harm and appears ***unclear*** as it pertains to risk for harm, the request will be reviewed by a physician.
     ii. Only a physician will determine if risk for harm does not apply

III. Reporting Technical Questions:

After reviewing the Exemption Transition Data File, Blue Shield Promise will submit any and all questions to MAXIMUS at: cahcohelpdesk@maximus.com, using *"MER/EDER Data File"* in the subject line of the email.

IV. Reporting Requirements:

1. Beginning with the reporting period of July 2017, Blue Shield Promise will submit a MMDR to LA Care or DHCS using the instructions and report template that are provided with this APL as Attachment B.

2. Blue Shield Promise will submit the MMDR to LA Care or DHCS Secure File Transfer Protocol (SFTP) site by the 15th day of the second month following the reporting period.

V. Processing Member Requests for Continuation of Covered Services:

1. Beneficiaries, their authorized representatives on file with their provider plan, or their provider, may make a direct request for continuity of care. Beneficiaries may file requests through Blue Shield Promise for continuation of covered services via facsimile, telephonically, or by mail.

   - Blue Shield Promise will accept requests for continuity of care over the telephone, according to the requester's preference, and shall 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.

2. The Beneficiary shall provide the following information:
   - Member Name
   - Date of Birth
   - Member ID#
   - Telephone number
   - Medical condition

- Services requested
- Treating provider's address, phone and specialty

3. UM staff shall document the medical exemption request in MHC database.

VI. Terms and Conditions with Non-Participating Provider:

1. Blue Shield Promise Health Plan may require a non-participating provider whose services are continued for a newly-covered enrollee to agree in writing to be subject to credentialing, utilization review, peer review, and quality improvement requirements.

2. If the non-participating provider does not agree to comply or does not comply with these contractual terms and conditions, Blue Shield Promise Health Plan is not required to continue the provider's services.

3. Unless otherwise agreed upon by the non-participating provider and Blue Shield Promise Health Plan, the services rendered shall be compensated at fee-for-service rate.

4. 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.

5. Blue Shield Promise Health Plan shall provide beneficiaries access to an out-of-network provider for up to 12 months if:
   - The beneficiary has an ongoing, prior relationship with the provider that can be documented using fee-for-service claims data;
   - 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**;
   - The provider has no quality of care issues and meets all credentialing requirements.

VII. Assessing the Terminated/Non-Participating Provider for Credentialing Qualification:

1. Credentialing Department shall notify the UM Department for the approval of the terminated or non-participating provider using the Credentialing Check Form (CCF).

2. If the requested terminated or non-participating provider meets the credentialing criteria, the UM staff shall 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 beneficiary.

3. Refer to Procedures, II (5) for Completion Timelines.

VIII. Medical Exemption Review Process of a Terminated/ Non-Participating Provider

1. If the credentialing criteria are not met, the completed CCF shall be forwarded by the Credentialing Department to the Chief Medical Officer or physician designee for review.
   - If not approved, the requested terminated or non-participating provider and the member shall be notified by the UM Department and an alternate provider shall be assigned.

2. The UM Department shall assess the request to:
    - 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);
    - Determine whether the member's condition is consistent with conditions or circumstances are set forth in APL 17-007;
    - Determine prior relationship with the requested provider through review of claims data from the State;
    - Active FFS Treatment Authorization Requests (TARs).

3. If the above are established, and the provider meets criteria and agrees to accept the higher of Blue Shield Promise Health Plan rates or FFS rates, Blue Shield Promise Health Plan shall offer a letter of agreement for:
    - Conditions and Timeframes for Completion of eligible covered services, as set forth in Section 1373.96.
    - Conditions and Timeframes for Completion of eligible covered services, as set forth in APL 17-007.

4. Blue Shield Promise Health Plan will work with the provider in establishing a treatment plan for the member.
    - 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.

5. If the provider refuses the rate, member is 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.
    - The member will have the option to select a contracted in-network provider of his or her choice.

6. Blue Shield Promise Health Plan shall document COC request outcomes in the member file.

7. Blue Shield Promise shall notify the member of the decision following the customary process of authorization determinations and notifications as they apply to requirements.
    - In the case of an adverse determination and the member disagrees with Blue Shield Promise Health Plan, the member can:
        i. File a grievance or Appeal;
        ii. Request a Medical Exemption from DHCS, assuming the request is within the first 90 days of enrollment in Blue Shield Promise Health Plan.

8. Other elements within the notification process will include the following:
    - The services approved
    - The duration of the COC arrangement
    - The process that will occur to transition the member's care at the end of the continuity care period.
        i. 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.

ii. The member's right to choose a different provider from the Plan's network.

iii. A list of contracted providers in the network will be provided for the member to select from.

IX. Beneficiary Education and Outreach Process

1. Members will be informed of COC provisions through:
    - Enrollment materials
    - Member Handbook
    - Welcome Calls
    - HRA process
    - Member Services outreach activities
2. Education materials will include the availability of COC materials in threshold languages and other alternative formats at the request of the member.

CONSIDERATIONS FOR TIMEFRAMES, PAYMENTS, AND EXCLUSIONS

I. Conditions and Timeframes for Completion of eligible covered services, as set forth in Section 1373.96(c):

1. **Acute condition**: Completion of covered services shall be provided for the duration of the acute condition.
2. **Serious chronic condition**: Completion of covered services shall be provided 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 Blue Shield Promise Health Plan, in consultation with the enrollee and the terminated provider or non-participating 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 enrollee.
3. **Pregnancy**: Completion of covered services shall be provided for the duration of the pregnancy. Including individuals with written documentation of being diagnosed with a maternal mental health condition, completion of covered services shall not exceed 12 months from the diagnosis or form the end of pregnancy, whichever occurs later.
4. **Terminal illness**: Completion of covered services shall be provided 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 enrollee.
5. **Newborn**: 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 enrollee.
6. **Performance of surgery or other procedure** that is authorized by Blue Shield Promise Health Plan, as part of a documented course of treatment and has been recommended and documented by the provider shall occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly-covered enrollee.

II. Conditions and Timeframes for Completion of eligible covered services, as set forth in APL17-007

1. An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the plan for a non-emergency visit.
    - If a beneficiary changes plans, the 12-month continuity of care period may start over one time. If the beneficiary changes plans a second time (or more), the continuity of care period does not start over, meaning that the beneficiary does not have the right to a new 12 months of continuity of care.
    - If the beneficiary returns to FFS and later re-enrolls in a plan the continuity of care period does not start over. If a beneficiary changes plans, this continuity of care policy does not extend to providers that the beneficiary accessed through their previous plan provider.

2. Newly enrolled Seniors and Persons with Disabilities (SPDs), that have any active FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by the Blue Shield Promise Health Plan.
    - And then COC will be arranged up to 12 months as defined by APL-18-008and Health & Safety Code Section 1373.96.

3. Covered California to managed care;
    - Blue Shield Promise shall contact the beneficiary by telephone call, letter, or other resources no later than 15 days after enrollment. Blue Shield Promise shall ask the beneficiary if there are upcoming health care appointments or treatments scheduled and assist the beneficiary to initiate the continuity of care process at that time.
    - Blue Shield Promise shall follow the initial outreach process as outlined in Procedures, I (4) and (5).
    - Blue Shield Promise will honor any active Prior Treatment Authorizations for up to 60 days or until a new assessment is completed by Blue Shield Promise.
        i. And then COC will be up to 12 months as defined by APL-17-007 and Health & Safety Code Section 1373.96

III. Payments:

1. The services rendered shall be compensated at 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.

IV. Exclusions and Quality Concerns:

1. 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.

2. 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.

3. This section shall not apply to a newly-covered enrollee who is offered an out-of-network option or to a newly-covered enrollee who had an option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

V. Delegated Oversight

1. Blue Shield Promise Health Plan shall ensure the delegates meet the requirements of HSC Section 1373.96 and APL 18-008.

2. Providers and Delegates will be educated on COC provisions through:
    a. Webinars
    b. Dissemination of Blue Shield Promise COC policy
    c. Provider Manual updates
    d. Individual Group onsite trainings

3. 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:
    a. Time frames for processing
    b. Copies of Organization Determination Notices
    c. Transition activities

REFERENCES

Health & Safety Code, Section 1373.96
APL-17-007
APL 18-008
APL 18-006
DPL 16-002
AB 577