blue california
Promise Health Plan

Policy Title: Continuity of Care for Terminated or Non-Participating providers/IPA/Hospital/Ancillary Services		POLICY #: 70.2.85 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 4/01/11	**Effective Date** 12/31/18	**Revision Date** 8/20, 06/21
Department Head: Sr. Director, UM		**Date: 12/21**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 12/21**	

PURPOSE

To establish a Mechanism for Blue Shield of California Promise Health Plan (Blue Shield Promise) to provide the completion of covered services for members upon termination of a provider or non-participating provider/IPA/Hospital/Ancillary Services.

POLICY

Blue Shield Promise shall, at the request of the enrollee, provide the completion of covered services by a terminated or out of network provider, in accordance with the Continuity of Care (CoC) requirements set forth in Health & Safety Code Section 1373.96.

1. The completion of covered services shall be provided by the 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.
2. The completion of covered services shall be provided by a non-participating provider to a newly covered enrollee who at the time his or her coverage became effective was receiving services from that provider for one of the conditions eligible for completion of covered services (please see UM policy 10.2.40).
3. Transition of care shall be implemented to members affected by a termination of provider/facility but are still in need of care.
4. Members who are in active course of treatment and who request for continuity of care due to termination of provider shall be granted.

Conditions and Timeframes for completion of eligible covered services, as set for in Health & Safety Code Section 1373.96(c):

1. Acute Condition: a medical condition that involves a sudden onset of symptoms due to illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
    a. Completion of covered services shall be provided for the duration of the acute condition.
2. 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 or requires ongoing treatment to maintain remission or prevent deterioration.
    a. Completion of covered services shall be provided for a period 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 enrollee and the terminated provider or non-participating provider and consistent with good professional practice.

b. 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: is the three trimesters of pregnancy and the immediate postpartum period, including maternal mental health.
    a. Completion of covered services shall be provided for the duration of the pregnancy; including individuals with documented maternal mental health, the completion of covered services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
    b. The postpartum period begins immediately after childbirth and extends for approximately six weeks.
4. Terminal illness: is an incurable or irreversible condition that has a high probability of causing death within one year or less.
    a. 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. The care of a newborn child between birth and age 36 months.
    a. Completion of covered services shall not exceed 12 months from contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
6. Specialty mental health services: up to 12 months continuity of care with the out-of-network Mental Health Plan.
7. Opioid Treatment Program (CMC): Blue Shield Promise will ensure the member may continue to see their current OTP provider while assisting the member in transitioning to a network provider.
8. Performance of a surgery or other procedure that is authorized by the plan 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 enrollee.
9. Members with an existing relationship: 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 their initial enrollment with Blue Shield Promise for a non-emergency visit.
10. Active course of treatment is when a member has regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

Member requests for Continuity of Care:

1. Member may file requests with Blue Shield Promise or a delegated Physician Provider Group (PPG) for CoC via facsimile, telephonically or by mail. Member shall include the following information:
    a. Name
    b. Date of birth
    c. Member ID#
    d. Medical Condition
    e. Service(s) requested
    f. Treating provider's phone number and specialty

2. If member files the request with Blue Shield Promise, the request will be reviewed by the Chief Medical Officer (CMO) to determine whether the member's condition is consistent with conditions set forth in Section 1373.96. Reasonable consideration shall be given to the potential clinical effect on a member'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 CoC.
3. If member 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. Reasonable consideration shall be given to the potential clinical effect on a member'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 Department of Managed Health Care (DMHC).
4. Decisions on members requests under this policy shall be made within 5 working days for non-urgent requests and within 72 hours for urgent request.
5. 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 Department of Health Care Services (DHCS) 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.

For transitions of care when benefits end, refer to *UM Policy 70.2.40*

Facility Decertification or Suspension:

1. Upon discovery of a facility decertification or suspension, Blue Shield Promise will terminate its contract with the facility, and take the following steps:
    a. Immediately notify DHCS of the contract termination with the facility due to decertification or suspension within five business days of receiving a final notification of a facility decertification and submit a Transition Plan and Network Review Documents as described in APL 21-003.
    b. Immediately suspend payment to the decertified or suspended facility for all Medi-Cal services provided after the effective date of the exclusion.
    c. Immediately notify all affected directly contracted providers of the decertified or suspended facility
    d. Provide notice to all impacted members as described in the Member Notice section of APL 21-003.
    e. Coordinate care for impacted members as required by federal and state law, and Blue Shield Promise's contracts with DHCS.
2. Blue Shield Promise will submit a Transition Plan to DHCS for approval regardless of the number of members impacted by the facility decertification or suspension and at minimum will include:
    a. A timeline for prompt transition of impacted members no sooner than 30 days after notification of the decertification, unless the member wishes to move sooner.
    b. A timeline for Blue Shield Promise case managers to contact and speak with all impacted members.
    c. A process to consult with the LTC Ombudsman and other related entities, as appropriate.

d. A process to work with impacted members, guardians, conservators, or personal representatives, as applicable, regarding the transition and the member's options or choices.
e. A process for the review of all impacted members' medical records, including a process for communication with members' providers as appropriate.
f. A plan of action to ensure that members' personal belongings are transitioned to the members' new providers in a timely manner.

3. Blue Shield Promise will send member notices within five days of receiving notification of the closure or effective date of the termination, and at minimum include:
    a. The effective date of the contract termination
    b. The name of the LTC facility
    c. The reason for the decertification
    d. A description of how the decertification will impact the member's access to covered services
    e. All language required by Health and Safety Code and the Knox-Keene Act
    f. Language providing the member with Blue Shield Promise's Customer Care telephone number and the toll-free telephone number of DHCS' office of the Ombudsman for questions or concerns.
    g. A description of how Blue Shield Promise will maintain the ability to provide covered services to impacted members
4. If the facility is residential and remains open, members have at least 30 days post-notice to transition to a new facility, with the following exceptions:
    a. The health and/or safety of a member in a facility is endangered;
    b. A member's health improves sufficiently so that the member no longer requires the services provided by the facility;
    c. A member's urgent medical needs require an immediate transfer or discharge;
    d. A member has not resided in a facility for 30 days or more;
    e. A member, their guardian, conservator, or personal representative has requested a transition to another facility; or
    f. A facility is no longer operational.
5. Members may choose not to transition to a new facility, however, they may be responsible for the costs of the services provided by the terminated or decertified facility.

Contract and Compensation Arrangement with Terminated Providers/IPA/Hospitals:

1. For terminated providers: Contract terms with contracted providers (primary care providers, specialists, ancillary care providers and hospitals) contracted directly by Blue Shield of California 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.
    a. 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.
2. 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 like

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.
    a. If the non-participating provider does not accept such payment rates or does not agree to such terms and conditions, then Blue Shield Promise/PPG is not required to continue the provider's services.
3. 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 contracted provider.
4. Blue Shield Promise is not required to:
    a. Continue services of any provider(s) whose contract is terminated or not renewed due to medical disciplinary reasons.
    b. Continue services that are not otherwise a covered benefit.
    c. Continue access to a practitioner unwilling to continue to treat the member
    d. Continue access if the member is assigned to a practitioner group, rather than to an individual practitioner, and has continued access to practitioners in the contracted group.
5. Blue Shield Promise will work with practitioners who are no longer under contract to develop a reasonable transition plan for each member in active treatment or postpartum period.

PROCEDURE

Member Identification:

The UM department will review all open encounters, referrals, and denials related to the affected provider, daily to identify members who are in active course of treatment, including:

1. Approved referrals for any outpatient services, specialty providers, and DME needs within the last 180 calendar days
2. Open and approved referrals within the last 180 days
3. Inpatient admissions for patients currently acute hospitals, skilled nursing facilities, acute rehabilitation units, and long-term care facilities
4. Open referrals for prenatal and postpartum services, if applicable to the provider.

Member Notification:

1. Members who are in active course of treatment shall be notified within 30 days prior to the termination of provider from the network.

Transition of care for LTC members:

1. Any member receiving LTC for an acute or chronic condition is managed by a Utilization Management (UM) case manager.
2. The UM case manager will coordinate with the Skilled Nursing Facility (SNF) case manager regarding members' medical coverage.
3. The UM case manager will verify eligibility during coordination of care with the SNF case manager and will review medical necessity for continued stay as a custodial member.

4. The UM case manager will send referrals to the Social Services department to request assistance with transition to new LTC facility.
5. The assigned Social Services case manager will outreach to all impacted members within 2 to 3 business days from receipt of the referral from the LTC UM department.
6. If the member declines transition support, the assigned Social Services case manager will discontinue outreach efforts and notify the UM case manager.

REFERENCES

AB 577
California Code of Regulations, Title 22, Sections 53852 and 53911
Health and Safety Code Section 1373.96
DMHC APL 19-013
DHCS APL 21-003