blue california
Promise Health Plan

Policy Title: Continuity of Care		POLICY #: 90.2.25 Line of business: CMC	
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Department Head: Mirela Albertsen, UM Senior Director			**Date:** 3/21
Medical Services/P&T Committee: (If Applicable) PHP CMO, James Cruz, MD			**Date:** 3/21

PURPOSE

To provide Blue Shield of California Promise Health Plan (Blue Shield Promise) Cal MediConnect Medicare-Medicaid(MMP)dual-eligible members a single benefit package that includes a full continuum of acute, primary, institutional, and home and community-based Medicare and Medi-Cal services delivered through an organized service delivery system. To prevent any disruption in care, Blue Shield Promise will ensure that newly enrolled dual-eligible members and those who were receiving treatment from a terminated provider at the time of the contract's termination, receive continuity of care for the following treatment and services:

1. Long Term Support Services (LTSS)
2. On-going treatment of a current acute or serious chronic condition, pregnancy, chronic mental health condition or terminal illness
3. Care of a new-born child between birth and 36 months
4. Documented maternal mental health condition for a period not exceeding 12 months from diagnosis or end of pregnancy, whichever occurs later
5. Opioid Treatment Program
6. Previously authorized surgery or other procedure from out-of-network provider.

Definitions:

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 is limited for the duration of the acute condition, but shall not exceed twelve (12) months from enrollment or the contact termination date for Medi-Cal and up to six (6) months, for primary and specialty Medicare services.

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 and is limited to the duration of the chronic condition but shall not exceed 12 months from enrollment or the contract termination date for Medi-Cal and up to six (6) months, for primary and specialty Medicare services.

Pre-Existing Relationship: A member has seen an out-of-network primary or specialty care provider at least once during the 12 months prior to the date of his or her initial enrollment in the MMP for a non-emergency visit.

Pregnancy: The three trimesters of pregnancy and the immediate postpartum period. Care shall be provided for the duration of the pregnancy and the immediate postpartum period, including maternal mental health.

Terminal Illness: An individual's medical condition as certified by a physician, results in a prognosis of life of one year or less if the disease follows its natural course.

Performance of a surgery or other procedure: The performance of a surgery or other procedure that has been authorized by the previous 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 effective date of coverage for a newly eligible member.

Long Term Services & Supports (LTSS): A wide variety of services and supports that help eligible beneficiaries meet their daily needs for assistance and improve the quality of their lives.

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.

Terminated Provider: A provider whose contract to provide services to members is terminated or not renewed by Blue Shield Promise or one of Blue Shield Promise's contracting provider groups, or by the provider.

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

Opioid Treatment Program (OTP): A program or practitioner engaged in opioid treatment of individuals with an opioid agonist medication.

POLICY

Blue Shield Promise Health Plan will follow continuity of care requirements for MMP members in accordance with established current law as defined in Welfare & Institutions Code §14132.275(k)(2)(A) and §14182.17 Section 1373.96 of the Knox Keene Act.

1. Blue Shield Promise will perform an assessment process within 90 days of a member's enrollment into the MMP program to ensure that continuity of care and coordination of care requirements are met for MMP members.

2. Blue Shield Promise will assure continuity of care for medical, behavioral health, Opioid Treatment Program (OTP), and long-term services and supports (LTSS), upon new enrollment and attempt to determine if beneficiaries have pre-existing provider relationships through previous utilization data, the HRA process, and as needed, contact with the beneficiary and/or their providers. Blue Shield Promise will allow enrollees to maintain their current providers and service authorizations at the time of enrollment for:

a. A period, up to twelve months, for primary and specialty Medicare and/or Medi-Cal (other than in-home supportive services (IHSS), services if all the following criteria are met:
    i. The enrollee demonstrates an existing relationship with the provider, prior to enrollment,
    ii. Blue Shield Promise will identify whether the member has seen the requested out-of-network primary or specialty provider at least once within the previous 12 months from the date of request.
    iii. The provider is willing to accept payment from the MMP based on the current Medicare or Medi-Cal fee schedule as applicable; and
    iv. Blue Shield Promise would not otherwise exclude the provider from their provider network due to documented quality of care concerns.

3. MMP Plan changes and new or Continued Continuity of Care Coverage Provisions
    a. Continuity of care will apply regardless of whether a beneficiary voluntarily joins or passively enrolls (e.g., beneficiary opted out of Cal MediConnect and later decided to join a Medi-Cal Managed Care Plan – MMP).
    b. If a beneficiary opts out or disenrolls from Cal MediConnect and later re-enrolls in Cal MediConnect, the beneficiary has the right to the continuity of care period, regardless of whether the beneficiary received continuity of care in the past.
    c. If the member changes MMPs, the continuity of care period may start over one time.
    d. If the member changes MMPs a second time (or more) the continuity of care period does not start over, meaning the member does not have a right to a 12-month continuity of care period.
    e. If the member returns to FFS Medi-Cal and later enrolls in Cal MediConnect, the continuity of period does not start over.
    f. If the member changes MMPs, the continuity of care policy does not extend to in-network providers that the beneficiary accesses through their previous MMP.

Payments:
The amount of, and the requirement for payment of, copayments, deductibles, or other cost-sharing components during the period of completion of covered services with a terminated provider or a non-participating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by Blue Shield Promise.

Exclusions:
Blue Shield Promise will not, nor is 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.

Other exclusions include:
- Services not covered by Medicare or Medi-Cal
- Providers of DME, transportation, other ancillary services or carved out services. However, Blue Shield Promise will ensure that each beneficiary continues to have access to medically necessary items and services, as well as medical and LTSS providers.
- The provider is not willing to accept payment form Blue Shield Promise based on current Medicare or Medi-Cal fee schedule.
- The provider does not agree to abide by Blue Shield Promise's utilization management policies.

- There is no evidence of an existing relationship between the provider and the member.
- There is documented quality of care concerns regarding the provide

Exception:

A member who is a long-term resident of a nursing facility prior to enrollment will not be required to change from a nursing facility during the duration of the Duals Demonstration Project if the facility meets the following conditions:

- Is licensed by the California Department of Public Health
- Meets acceptable quality standards
- The facility and the MMP agree to Medi-Cal rates in accordance with the three-way contract.

PROCEDURE

Requests for Continuation of Covered Services:

1. Members, their authorized representatives on file with Medi-Cal, or their providers may file requests through Blue Shield Promise for continuation of covered services via facsimile, telephone, or mail. Requests for continuation of covered behavioral health services may be made directly to Blue Shield Promise's delegated managed behavioral health organization (MBHO) and will be processed by the MBHO as delegated
2. Member 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. When a continuity of care request is made, Blue Shield Promise will initiate the process within five (5) days of receiving the request; However, the request must be completed In three (3) days if there is a risk of harm to the beneficiary.
4. The continuity of care process begins when Blue Shield Promise determines that there is a pre-existing relationship and has entered into an agreement with the provider.
5. The process is documented in the Blue Shield Promise MHC database
6. The UM Department shall assess the request to determine whether the member's condition is consistent with set forth in Health and Safety Code 1373.96 and Welfare Institution Code 14182(b)(13) and (15) to continue services with a non-participating provider.
7. UM Department will identify whether the member has seen the requested out-of-network specialty provider as per section 2A of this policy from the date of the request, to determine prior relationship with the requested provider through review of Medicare and Medi-Cal fee-for-service claims data from the State.
8. UM Department will evaluate the provider for quality of care issues through a brief credentialing assessment.
    - UM staff shall complete a Credentialing Check Form and forward it to Credentialing Department.
9. If the above are established, for Medi-Cal or Medicare services covered under the Demonstration, Blue Shield Promise shall offer a Blue Shield Promise Plan rate for the service offered or applicable Medi-Cal rate or Medicare rate, and letter of agreement for the 12-month continuity of care period.
    - If the provider agrees, the member may continue to see the provider for up to 12-month period with prior authorization based on medical necessity

- If the provider refuses the rate, member is verbally notified and then re-directed to an in-network provider who is qualified to evaluate and treat the member's condition.

10. Blue Shield Promise shall document outcome in member file and shall notify the member of decision.
    - If the member disagrees with Blue Shield Promise, the member can:
        i. File a grievance; (refer to Grievance P&Ps 10.19.5 Beneficiary Grievance Management System).
        ii. Request a Medical Exemption from DHCS – assuming the request is within the first 90 days of enrollment in Blue Shield Promise Health Plan.
11. For continuity of care requests that result in an adverse internal organization determination for not meeting criteria please refer to: Policy and Procedure 70.2.42 titled "Utilization Management Standards for Medical Decision-Making Process"
12. A continuity of care request must be completed within:
    - 30 calendar days from the date of receipt of the request
    - 15 calendar days if the member's medical condition requires more immediate attention such as upcoming appointments or pressing care needs
    - Three calendar days if there is risk of harm to the beneficiary.
13. A continuity of care request is considered completed when:
    - The beneficiary is informed of his or her right to continued access or if the MMP and the out-of-network FFS or prior plan provider are unable to agree to a rate
    - The MMP has documented quality of care issues; or
    - The MMP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.
14. Upon completion of a continuity of care request, Blue Shield Promise will notify beneficiaries of the following within seven (7) calendar days:
    - The request approval or denial, and if denied, the beneficiary's appeal and grievance rights
    - The duration of the continuity of care arrangement
    - The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and
    - The beneficiary's right to choose a different provider from the MMP's provider network
15. Blue Shield Promise and/or its delegate will notify beneficiaries 30 calendar days before the end of the continuity of care period about the process that will occur to transition care at the end of the continuity of care period. This process will include engaging with the beneficiary and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

Retroactive Requests:

1. Blue Shield Promise or its delegated MBHO will approve any retroactive requests that meet the following requirements:
    a. Have dates of services that occur after September 29, 2014.
    b. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement: and
    c. Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested or denial from another entity when the claim was incorrectly submitted.

Blue Shield Promise or its delegated MBHO will accept retroactive requests that are submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request

is sent within 30 days of the denial to CMS (as a Medicare FFS claim), another MA plan, or the prime plan instead of the delegated IPA.

Assessing the Non-Participating Provider:

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 Form to Provider Network Operations (PNO) to offer a one-time letter of agreement.
3. 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.
    a. 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.

Delegated Providers:

Blue Shield Promise shall ensure the delegates meet the requirements of this policy.

Member and Provider Outreach and Education:

1. Members will be informed of Continuity of Care provisions in enrollment materials and the Member Handbook.
2. The Customer Care Department staff will be in-serviced on CoC provisions to assist member when they call Blue Shield Promise to request information about or assistance with a COC request.

REFERENCES

- CMS-CA MOU for Medicare-Medicaid Enrollees
- Health & Safety Code 1373.96(C)
- Welfare and Institutions Code, Section W&I Code §14132.275(k)(2)(A) and §14182.17
- Duals Plan Letter 16-002 "Continuity of Care"
- CMS HR6 Section 2005
- AB 577
- Three-way contract (CMS, DHCS, MMPs)