I. PURPOSE

The purpose of this policy is to provide a mechanism to arrange for the continuity of care for members undergoing treatment with a provider at the time of the provider's contract termination or when a newly enrolled member is receiving services for a qualifying condition from a non-contracted provider at the time coverage becomes effective or when member benefits end.

II. POLICY

A. It is the policy of Scripps Health Plan Services (SHPS) to provide continuity of care in accordance with state and federal guidelines for members currently receiving a course of treatment from a terminated provider and for new members who are undergoing an active course of treatment from a non-participating provider. Member notification is made at least 60 days prior to termination of provider.[1]

B. SHPS will assist with transition of care for a member whose benefits or benefit period, under managed care, have ended to another source of care of payment.[2]

C. When SHPS is responsible for approving a continuity of care request, SHPS shall process the request as described herein.

D. **SHPS members**: Requests for continuity of care which are the responsibility of the health plan shall be forwarded upon receipt.

E. **SHP members only**: Members receive information regarding their continuity of care rights upon enrollment and at least 60 calendar days prior to the effective date when a provider leaves the network.

F. Completion of covered services shall be provided for the following conditions:

1. An acute condition: Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition (example: 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): Completion of covered services for a serious chronic condition shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly enrolled member.

[1] CA Health & Safety Code §1373.65 (b)

[2] CA Health & Safety Code §1367 (d)

3. A serious and complex medical condition (example: acute illness, a condition serious enough to require specialized medical care to avoid reasonable possibility of death or permanent harm or a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged time): Completion of covered services shall be provided for the time period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by SHPS in consultation with the member and the terminated/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 enrolled member.
4. A pregnancy: Completion of covered services shall be provided for the duration of the pregnancy.
5. A maternal mental health condition: Completion of covered services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
6. The care of a newborn child between birth and age 36 months: 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 member.
7. Performance of a surgery or other procedure (including postoperative care): Authorized by the plan as part of a documented course of treatment and has been recommended and documented by the non-contracting provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage with the plan.
8. Inpatient or institutional treatment: Completion of covered services shall last the earlier of 90 days from the date the notice of the right to elect continuing care is provided to the member or the date on which the member is no longer undergoing continuing care by that provider or facility.
9. A 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 newly covered member.
10. Continued transitional care services when elected by an eligible member who is receiving inpatient care and the employer group terminates coverage with the health plan and transitions to another carrier.[3]

G. If a condition falls within a qualifying condition under federal and state law, the more generous time frames would be followed.
H. Enrollees are allowed to maintain their current providers and service authorizations at the time of enrollment for a period, up to 12 months, for Medicare and MediCal services covered under this policy other than in-home supportive services (IHSS), DME, transportation, other ancillary services or carved out services.

[3] CA Health & Safety Code §1373.96 (b)(c)

I. If a Skilled Nursing Facility resident leaves and then requires a return to a Skilled Nursing Facility level of care due to a medical necessity, the beneficiary has the right to return to the same Skilled Nursing Facility where he/she previously resided under the Leave of Absence and Bedhold policies.[4,5,6]

J. The terminated provider whose services are continued beyond the contract termination date may be required to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider before termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, SHP is not required to continue the provider's services beyond the contract termination date.[7]

K. A nonparticipating provider whose services are continued for a newly covered enrollee may be required to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.[8]

L. Unless otherwise agreed upon by the terminated/nonparticipating provider and SHPS or by the individual provider and the provider group, the services rendered shall be compensated at rates and methods of payment similar to those used by SHPS or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated/nonparticipating provider. Neither SHPS nor the provider group is required to continue the services of a terminated/nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.
    1. For terminated providers, acceptance of the same rate and method of payment for services rendered that was present under the provider’s contract at the time of the termination, Medicare rates for senior members, or an agreed upon rate less than billed charges.

M. 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 nonparticipating provider are the same as would be paid by the member if receiving care from a provider currently contracting with or employed by SHPS.

N. Exemptions to this policy include the following:

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[4] 28 CCR 72520 (a)(b)
[5] CA Health & Safety Code §1367.09
[6] 42 CFR 483.15 (d)(e)
[7] CA Health & Safety Code §1373.96 (d)
[8] 42 CFR 483.15 (d)(e)

1. SHPS 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, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.
2. SHPS is not required to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.
3. SHPS is not required to cover services to a newly covered member who is offered an out-of-network option or to a newly covered member who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.[9]

O. When reviewing requests for continuity of care, adequate review criteria that meets community standards of practice is used to determine whether the member's current care and treatment is transferrable to another provider without compromising the quality of care.

P. **SHPS members**: SHPS shall provide a written copy of this information to its contracting providers and provider groups. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any notices regarding termination of coverage or provider contract termination.

Q. **SHP members only**: If SHP delegates the responsibility of complying with this section to a provider group, SHP shall ensure that the requirements of this policy are met. Notice as to the process by which a member may request completion of covered services shall be provided in every disclosure form and in any evidence of coverage. SHP shall provide a written copy of this information to its contracting providers and provider groups. SHP shall also provide a copy to its members upon request. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any notices regarding termination of coverage or provider contract termination.

R. If a member's benefit ends or does not have an adequate benefit to meet their need and still requires medical services, the Utilization Management (UM) Department will inform the member of other alternative sources and methods of obtaining services.
   1. Referral to Complex Care Management to assist with
      a. Recommend community resources and how to access the resources
      b. Recommend social service interventions through the community or selected facilities
      c. Work with the member's health plan to access other benefits which might meet the member's need.

III. DEFINITIONS

A. **An 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.

[9] CA Health & Safety Code §1373.96 (h)(i)(j)

B. **A 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.
C. **A serious and complex condition:** For an acute illness, a condition serious enough to require specialized medical care to avoid reasonable possibility of death or permanent harm. For a a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged time.
D. **A pregnancy**: The three trimesters of pregnancy and the immediate postpartum period.
E. **A maternal mental health condition**: A mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
F. **A terminal illness**: An incurable or irreversible condition that has a high probability of causing death within one year or less.
G. **Transitional care services**: Services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another. (e.g., hospital to skilled nursing facility or return to home, primary care to specialty care).

IV. PROCEDURES

A. Continuity of Care
    1. Upon receipt of a request for continuity of care, the Utilization Management Department shall process the request as described in policy SHPS 800 *Prospective Authorization Review*.
    2. SHPS requests previous health plan and/or providers to identify which of their cases require specialized coordination of care and services and facilitates a case review with the previous health plan and/or provider in advance of the transition.
    3. With reasonable consideration given to the potential clinical effects on the member's treatment caused by a change in provider, SHPS reviews requests and makes a determination for members that may require continuation of services.
        a. This is accomplished by reviewing appropriate medical records, in collaboration with the physician reviewer and the treating provider.
        b. The duration of services covered under this policy takes into account on a case- by-case basis, the severity of the member's condition and the amount of time reasonably necessary to affect a safe transfer.
B. For nonparticipating providers, if the Utilization Management Department agrees to the continuation of care, information will be forwarded to the Provider Relations department to complete a letter of agreement.
C. Should any problems with the provider's compliance with the terms of the contract be identified, the Utilization Department is to notify the Manager, Quality Management, Provider Relations and Contracting, immediately.
D. Transition of Care to a Participating Provider

1. SHPS has established policies and procedures for the safe planned and unplanned transfer of care of new and existing members with acute, serious chronic medical and/or mental health conditions who are currently receiving services from a nonparticipating medical and/or mental health provider to a participating provider.
2. SHPS will coordinate with the current provider to facilitate a smooth transition and make the following available upon request:
    a. A written description of its process for facilitating continuity of care.
    b. A written description of its review process for requests to continue services with an existing provider not contracted with SHPS or SHP.
    c. If requested by the patient and to ease referral and physician selection, SHPS will provide a list of available participating providers and information for contacting those providers.
    d. If requested by the patient, it is appropriate for the current physician to suggest a physician to the patient and then to begin communication with that physician.
3. The Medical Director will be contacted by the Utilization Management Department or the PCP if any problem occurs with the transfer to another participating provider. The Medical Director will determine the safety of a transfer and direct Case Management staff in the process of either approving continuing treatment with a terminated provider or transferring care to a new contracted provider.

E. In accordance with current laws and regulations, members being transitioned to a new participating provider will be given their appeal rights should they disagree with such a transfer. Members can receive a copy of the Continuity of Care Policy on request by contacting the customer service number on their enrollment card. Appeal rights notifications will include the following language:

> "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your health plan's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects consumers, by telephone at its toll-free number, 1-888-466-2219, or at a TTD number for the hearing and speech impaired at 1-877-688-9891, or online at www.dmhc.ca.gov."[10]

V. REFERENCES

CA Health & Safety Code § 1367 (d), 1373.65 (b); 1373.95(a)(2); 1373.96
28 CCR 1300.67.1.3 (b)(1)(l)

[10] 28 CCR 1300.67.1.3 (b)(1)(I)

CA Business & Professions Code 805(a)(6)
2022 NCQA Medicare Advantage Standards 22, Element D
2022 NCQA Network Management Standards 4, Elements A & B

VI. RELATED POLICIES

SHPS 1209 "PCP/Specialist Termination Process"
SHPS 800 "Prospective Authorization Review"
SHP 1203 "Block Transfers"

VII. ATTACHMENTS

A. Continuity of Care Request Form

HISTORY	
Reviewed: 06/01/08, 04/06/10, 04/09/12, 04/19/13, 04/16/15, 06/08/15, 08/28/17, 04/25/18, 8/24/18, 06/12/19, 07/16/19, 04/24/20, 06/23/21	**Revised:** 05/17/09, 04/25/14, 08/28/17, 08/24/18, 06/12/19, 07/26/19, 02/28/20, 04/08/20, 12/20/21, 01/28/22, 06/21/22, 10/10/22, 11/02/22

ENDORSEMENTS and APPROVALS		
Approvals		**Approval Date**
P&P Chair	DocuSigned by: Monique Koch 60C19FA019B64DB...	**11/18/22**
P&P Co-Chair	DocuSigned by: Maria L. Cate AA53D31BBACA48B...	**11/18/22**
Business Owner	DocuSigned by: Deborah Bennett 408332223023466...	**11/18/22**
Medical Director	DocuSigned by: Dan Dworsky, MD DCDA1AD1C7094D7...	**11/18/22**