TITLE: Continuity of Care

IDENTIFIER: SHPS 803
DEPARTMENT: Utilization Management

EFFECTIVE DATE: 02/28/2020

Applies to:
- ☒ **SHPS – Medicare Advantage+**
- ☒ **SHPS – Commercial**
- ☐ **Scripps Health Plan**

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 tem1ination or when a newly enrolled member is receiving services for a qualifying condition from a non-contracted provider at the time coverage becomes effective.

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 nonparticipating provider. When SHPS is responsible for approving a continuity of care request, SHPS shall process the request as described herein. Requests for continuity of care which are ilie responsibility of the health plan shall be forwarded upon receipt.

B. 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: 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 SHP 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.
3. A pregnancy: Completion of covered services shall be provided for the duration of the pregnancy.
4. 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.
5. 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 new member.

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 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 member.
8. A mental health condition: Completion of covered services shall take 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.

C. 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 Medi Cal services covered under this policy other than in-home supportive services (IHSS), DME, transportation, other ancillary services or carved out services.
   1. If an enrollee opts out or disenrolls from Cal Mediconnect and later reenrolls in Cal Medicom1ect, the enrollee has the right to a 12-month continuity of care period regardless of whether the enrollee received continuity of care in the past.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. Exemptions to this policy include the following:

I . 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.

J. 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.

K. 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.

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.

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 pregnancy:** The three trimesters of pregnancy and the immediate postpartum period.

D. **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.

E. **A terminal illness:** An incurable or irreversible condition that has a high probability of causing death within one year or less.

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 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 effect 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.

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 notificationswill 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."

F. **Cal Medi-Connect Specific Policy:**

1. For Long Term Supportive Services (LTSS), there shall be no disruption in services provided to the enrollee [Note Scripps Health Plan Services is not responsible for the provision of LTSS services but coordinates with the provider]. For cases involving a pregnancy, services must be provided during the three trimesters of pregnancy until postpartum services related to the delivery are completed or for a longer period if necessary.
2. SHPS will notify Health Net when Cal MediConnect members directly request continuity of care from SHPS for medical, behavioral health, and long term services and supports. Health Net will determine if the member meets continuity of care criteria of member seen by a non-network provider twice in the last 12 months. Once verified that the member meets criteria, SHPS will assure continuity of care for medical, behavioral health, SNF, and long-term services and support and request a letter of agreement. If the provider agrees to accept payment rates and is not excluded from the plan for quality or other reasons, the member can continue to see the provider for 6 months after enrollment for Medicare services and 12 months for Medi-Cal services. A Continuity of Care request is considered complete when the member is informed of his or her right to continued access and care coordination is performed, Continuity of care will be denied if SHPS and the out of network provider are unable to agree to a

rate, SHPS has documented quality of care issues regarding the requested provider, or SHPS makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

a. **Cal MediConnect Continuity of Care Decision-Making:**
   i. Begin to process the request within five working days after receipt of the request. However, the request must be completed in three (3) day if there is a risk or harm to the beneficiary.

b. **Must be completed within the following timeline:**
   i. 30 calendar days from the date the MCP received the request
   1i. 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs or
   iii. 3 calendar days if there is risk of harm to the beneficiary
   iv. Upon receipt of the continuity of care request, SHPS shall notify the beneficiary of the following within seven calendar days:
      A. The request approval
      B. The duration of the continuity of care arrangement
      C. The process that will occur to transition the beneficiary's care at the end of the continuity of care period and
      D. The beneficiary's right to choose a different provider from the plan's provider network.

3. For HN Cal Medi Connect, retroactive requests for continuity of care will be accepted and approved when the requirements in section I. are met with the exception of the requirement to abide by the organization's Utilization Management policies; the services occurred after the member's enrollment in the plan; and the plan must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment. Retroactive requests can only be approved if the dates of service occur after 9/29/14, dates of service are within 30 calendar days of the first date of service for which the provider is requesting continuity of care retroactive reimbursement, and are submitted within 30 calendar days of the first service for which retroactive continuity of care reimbursement is being requested. Retroactive requests that are submitted more than 30 days After the first service may be accepted if the provider can document that the reason for the delay is that the request was sent, without intention, to the wrong entity and the request is sent within 30 days of the denial from the incorrect entity. Healthnet is responsible for processing continuity of care requests inclusive of timeframes and letter notification.
4. For HN Cal MediConnect, when a request for continuity of care is made, the member will be notified 30 calendar days before the end of the continuity of care period about the process that will occur to transition the beneficiary's care at the end of the continuity of care period. This will include engagement 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.
5. For HN Cal MediConnect, when a beneficiary is a resident of a nursing facility prior to enrollment does not have to request authorization to remain in the SNF and will not be required to change SNF during the duration of CMC if:
   a. The facility is licensed by California Department of Public Health.

b. The facility meets acceptable quality standards.
c. The facility and organization agree to Medi-Cal rates in accordance with the three-way contract.
d. The organization shall determine the duration of the residency through the same process specified previously for verifying a pre-existing provider relationship, which is through historical utilization data or documentation from the beneficiary or provider.