CONTINUITY OF CARE PROGRAM DESCRIPTION

Purpose and Scope of the Quality Assurance Program

The Purpose of the Continuity of Care program established within the VCHCP for the enrollees is designed to ensure proper transitions of care for the enrollees between levels of services administered, service providers and throughout the spectrum of life’s stages. This continuity will be ensured through primary care, specialty care, acute care, rehabilitation, hospice, home care, behavioral health services and ancillary services such as physical therapy and occupational therapy. Continuity also applies to tests and procedures performed in the course of treatment.

Coordination may occur though established documents transmitted between providers, through telephonic communication and electronic communication. This applies with all levels of services, including but not limited to coordination between behavioral health services and primary care.

Oversight of the evidence of the communication / coordination between providers as demonstrated through the utilization of the tools occurs during the annual delegation oversight audits of delegated entities and during chart review performed by the Plan.

The Scope of the VCHCP’s Program Description is three-fold:

The Medical Home: To provide for the Coordinating the provision of health care services to each enrollee. This will include encouraging each enrollee to select a primary care physician (PCP), the maintenance and readily available access to medical records, and ensuring an adequate system of documentation to the physicians. An adequate network of physicians will be made available to the enrollees to ensure regulatory access and availability for urgent, routine and preventive health care.

The New Enrollee: To ensure that VCHCP provides for appropriate continuity of care for new enrollees.

To provide, for the benefit of the enrollees, Plan procedures to ensure a smooth transition to a new Provider, to complete a course of treatment with the same Provider, or to maintain the same Provider under certain circumstances. Reasonable consideration will be given to the potential clinical effects of the enrollee’s treatment caused by the change in Provider.

By the Terminated Provider: To ensure that VCHCP provides for appropriate continuity of care for enrollees whose Provider is no longer contracted with the Plan. The Plan is not required to continue services for any Provider whose contract is terminated or not renewed for reasons relating to medical disciplinary reasons or fraud or other criminal activity.

To clarify the rights of enrollees when a disruption of the Plan’s Provider network occurs.

To provide, for the benefit of the enrollees, Plan procedures to ensure a smooth transition to a new Provider, to complete a course of treatment with the same Provider, or to maintain the same Provider under certain circumstances. Reasonable consideration will be given to the potential clinical effects of the enrollee’s treatment caused by the change in Provider.
CONTINUITY OF CARE FOR A NEW ENROLLEE

PURPOSE:
- To ensure that VCHCP provides for appropriate continuity of care for new enrollees.
- To provide, for the benefit of the enrollees, Plan procedures to ensure a smooth transition to a new provider, to complete a course of treatment with the same provider, or to maintain the same provider under certain circumstances. Reasonable consideration will be given to the potential clinical effects on the enrollee’s treatment caused by the change in provider.

DEFINITIONS:
“Provider” means any professional person, organization, health facility, or other person or institution (including a hospital) licensed by the state to deliver or furnish health care services.
“Non-Participating Provider” means a provider who is not contracted with the Plan.

PROCEDURE:
This policy shall be made available to enrollees upon request.

1. Notice Requirements:
   When possible, prior to the coverage effective date for a new enrollee receiving care from a Non-Participating Provider, the Plan will notify a new enrollee receiving care from that provider. This notification is by means of the “new enrollee packet”, which is sent to all new enrollees and includes: the member ID card, the Plan’s “Welcome Letter”, the EOC, the Provider Directory, HIPAA Privacy Notice and HFP/AIM Verification form, when appropriate. Information in the packet will include effective date on the new enrollee’s ID card, and a statement of the enrollee’s right to the completion of certain covered services by the Non Participating Provider and a Plan contact to facilitate the transition–both of which are found in the “Welcome Letter”.

2. Upon request of the new enrollee or the new enrollee’s Non-Participating Provider, or on the recommendation of Member Services, the new enrollee’s transition will be reviewed on clinical grounds by the Medical Director, via the UR Nurse.
   A. Enrollees may make the request for continuity of care by contacting Member Services by phone at (805) 981-5050 or (800) 600-8247, M-F, 8:30 AM – 4:30 PM, excluding holidays.
   B. Member Services will log the request into the Plan’s Customer Service Telephonic Communication log and will mail a copy of the Plan’s Continuity of Care Policy (contained in the Evidence of Coverage booklet) to the enrollee’s home.
   C. Member Services will connect the enrollee to a representative in UM for clarification and review of the Continuity of Care process.
   D. In the communication log, Member Services will confirm eligibility effective date and document the responses from the enrollee concerning eligibility for continuity of care. A copy of the log will be forwarded to the Plan’s Medical Director via the UM Representative.

3. The UM Representative will consult, if needed, with the Medical Director, in a timely manner, decide on a case by case basis whether a transition period of care provided by the Non-Participating Provider is indicated, and if indicated, the duration of the transition. All decisions
Coverage will be considered for:

A. Ongoing treatment for an acute condition of limited duration: An acute condition is 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. Completion of covered services shall be provided for the duration of the acute condition.

B. A serious chronic condition: A serious chronic condition is 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. 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 the Plan in consultation with the enrollee and the Non-Participating Provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.

C. Pregnancy: A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

D. A terminal illness with a high probability of death within one year: A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the effective date of coverage for a new enrollee.

E. The care of a newborn child between birth and 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the effective date of coverage for a newly covered enrollee.

F. The performance of a surgery or other procedure that is authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the effective date of coverage for a newly covered enrollee.

4. The Plan may require the Non-Participating Provider to agree to all terms and conditions, including non-capitated payments, applicable to participating providers, as a condition of continuing to provide services.

5. If the Non-Participating Provider does not agree to comply or does not comply with these terms and conditions, the Plan is not required to continue the Provider’s services.

6. Providers shall be compensated at rates and methods of payments similar to those used by the Plan for currently contracting providers of similar services who are not capitated and are practicing in the same or similar geographic area as the Non-Participating Provider. The Plan is not required to continue the services of a Non-Participating Provider if the provider does not accept these payment rates.

7. All existing Plan cost sharing arrangements will remain in force.

8. The Plan will not be required to cover services or provide benefits not otherwise covered under the terms and conditions of the Plan EOC or contracts.

9. The Plan will not be required to provide Continuity of Care for to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.
CONTINUITY OF CARE BY A TERMINATED PROVIDER
PURPOSE:

• To ensure that VCHCP provides for appropriate continuity of care for enrollees whose Provider is no longer contracted with the Plan. The Plan is not required to continue services of any Provider(s) whose contract is terminated or not renewed for reasons relating to medical disciplinary reasons or fraud or other criminal activity.
• To clarify the rights of enrollees when a disruption of the Plan’s Provider network occurs.
• To provide, for the benefit of the enrollees, Plan procedures to ensure a smooth transition to a new Provider, to complete a course of treatment with the same Provider, or to maintain the same Provider under certain circumstances. Reasonable consideration will be given to the potential clinical effects on the enrollee’s treatment caused by the change in Provider.

DEFINITIONS:

“Provider” means any professional person, organization, health facility, or other person or institution (including a hospital) licensed by the state to deliver or furnish health care services.
“Terminated Provider” means any Provider no longer a part of the Plan Provider network. This policy applies to Providers whose contract with the Plan was terminated for reasons other than a medical disciplinary cause, fraud or other criminal activity.

PROCEDURE:

This policy shall be made available to enrollees upon request.

1. The Plan’s Member Services Department (805) 981-5050 is responsible for overseeing the process of transferring the enrollee from the care of the Terminated Provider to the care of a new Plan Provider. This includes enrollee block transfers, should the occasion for such a transfers arise, or individual letters to the affected members advising them of the terminated provider and the name of a provider they can transfer their care to.

2. Filing Requirements: The Plan will submit a block transfer filing to the Department at least 75 days prior to the termination of a contract between the Plan and a Provider group or general acute care hospital.

3. Notice Requirements:
   a. At least 60 days prior to the termination of the contract between the Provider and the Plan (absent termination with cause), the Plan will notify enrollees receiving care from that Provider. If the terminating Provider is a hospital, the Plan will notify enrollees who are within a 15-mile radius of the terminating hospital. The notification will include date of termination or effective date, a statement of the enrollee’s right to the completion of certain covered services by the terminating Provider, and a Plan contact to facilitate the transition.
   b. With regard to the notification to enrollees, the Plan shall submit the template for such notice to the Department of Managed Health Care (“Department”) for approval at least 75 days prior to its use. The Department has 7 calendar days to approve or to specify changes to the submitted notice. IF the Department does not respond within this timeframe, the notice is deemed approved.
   c. With regard to the notification to enrollees of the option to return to the former Provider, if the Plan reaches an agreement with the Terminated Provider to renew
or enter into a new contract or to not terminate the old contract, the Plan shall notify members of that option by sending the Recontracted Provider Notice Letter (attached) within 10 (ten) working days from the Plan’s receipt of the agreement with the Terminated Provider.

d. With regard to the notification to enrollees, if the Terminated Provider is a behavioral health Provider under contract to the Plan’s contracted Behavioral Health Administrator (BHA), the Plan delegates responsibility of the notice requirement to the BHA.

e. With regard to the notification to enrollees, if the Plan is unable to comply with the 60-day notice requirement timeframe due to exigent circumstances, the Plan shall apply to the Department from a waiver. The Plan is excused from complying with this requirement only if its waiver application is granted by the Department or the Department does not respond within seven days of the date of its receipt of the waiver application. Such exigent circumstances may include termination with cause or the Plan becoming aware of the termination after deadlines to file with the Department has passed.

4. Upon request of the enrollee or the enrollee’s Terminated Provider, or on the recommendation of Member Services, the enrollee’s transition will be reviewed on clinical grounds by the Medical Director.

a. Enrollees may make the request for continuity of care by contacting Member Services by phone at (805) 981-5050 or (800) 600-8247, M-F, 8:30 AM – 4:30 PM, excluding holidays.

b. Member Services will log the request into the Plan’s Customer Service Telephonic Communication log and will mail a copy of the Plan’s Continuity of Care Policy to the enrollee’s home (outlined in EOC).

c. Member Services will connect the Enrollee to a representative in UM for clarification and review of the Continuity of Care process.

d. In the communication log, Member Services and UM will document the responses from the enrollee concerning eligibility for continuity of care and code the logs with “continuity of care”.

5. The UM Representative, will consult, if needed, with the Medical Director, in a timely manner, decide on a case-by-case basis whether a transition period of care provided by the Terminated Provider is indicated, and if indicated, the duration of the transition. All decisions will be communicated in writing to the enrollee and the Provider involved in the enrollee’s care. Coverage will be considered for:

a. Ongoing treatment for an acute condition of limited duration: An acute condition is 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. Completion of covered services shall be provided for the duration of the acute condition.

b. A serious chronic condition: A serious chronic condition is 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. 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 the Plan in consultation with the
enrollee and the Terminated Provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.

c. Pregnancy: A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

d. A terminal illness with a high probability of death within one year: A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may not exceed 12 months from the contract termination date.

e. The care of a newborn child between birth and 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date.

f. The performance of a surgery or other procedure that is authorized by the Plan as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 180 days of the contract’s termination date.

6. Block Transfers are implemented using the same procedures as individual transfer procedures, noting that, for all Providers:

a. The Plan has established the following geographic access standards:

   i. Plan Provider panel is maintained at sufficient primary care Provider office levels to meet regulatory requirement. Enrollees will be reassigned to a Primary Care Provider who is within 30-minutes/15-miles of the enrollee’s residence.

   ii. Plan hospital Provider panel is maintained at sufficient levels so that the residence or workplace of enrollees will be within 30-minutes/15-miles of a contracted hospital. Concurrent with an agreement with a hospital, the Plan establishes contracts with PCPs who have admit privileges at the hospital.

   iii. Plan Provider panel members are required to maintain at least one full-time equivalent physician for each 1200 enrollees; there shall be one full-time equivalent primary care physician for each 2000 enrollees.

   iv. Contracted alternative hospital Provider panel members within the Plan’s service area are required to be accredited acute care facilities. The Plan will verify that the alternate hospital(s) has the same range of services as the terminated hospital. Current copies of The Joint Commission certification are required to be provided to the Plan. Acute care facilities are audited biennially by the Plan’s certified credentialing specialists.

b. The Plan will monitor access and availability, utilizing the NIS Reports (GeoAccess) required to be submitted quarterly to MRMIB. In addition, Plan-initiated surveys are utilized which document and track accessibility information on: hours of operation, call arrangements, wait-times, appointment scheduling, ER visit tracking, credentialing/hospital privilege requirements, administrative capacity to accept/maintain enrollees, and complaints/grievances/disenrollment surveys and regulatory reporting. The Plan does not verify financial capacity of a
Provider to accept and maintain enrollees, as the Plan does not delegate claim processing or administrative responsibilities to the Providers.

c. In the event of the termination of a agreement with a hospital, the Plan will (1) pull a data report of all enrollees who reside within 15 miles of the hospital, (2) advise these enrollees, in writing, of the termination date and the alternative hospital facilities available to them within the plan’s service area, and (3) advise the enrollees of pending negotiations with a replacement hospital (if necessary). Subsequent to any addition of this replacement hospital (if necessary) to the hospital Provider panel, a follow-up letter will be sent to affected enrollees when contractual arrangements are complete.

7. The Plan may require the Terminated Provider to agree to all terms and conditions, including non-capitated payments, applicable to participating Providers, as a condition of continuing to provide services.

8. If the Terminated Provider does not agree to comply or does not comply with these terms and conditions, the Plan is not required to continue the Provider’s services beyond the contract termination date.

9. Providers shall be compensated at rates and methods of payments similar to those used by the Plan for currently contracting Providers of similar services who are not capitated and are practicing in the same or similar geographic area as the Terminated Provider. The Plan is not required to continue their services of a Terminated Provider if the Provider does not accept these payment rates.

10. All existing Plan cost sharing arrangements will remain in force.

11. The Plan will not be required to cover services or provide benefits not otherwise covered under the terms and conditions of the Plan’s EOC or contracts.