



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”, and Member Materials Guide, and HIPAA Privacy Notice. 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. Member Services will advise the member and/or the non-participating provider to submit a Treatment Authorization Request (TAR) to the UM Department via fax for the services being requested.

- 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, upon request.

- C. Member Services will advise the member and/or the non – contracted provider that the Plan's UM department will review the medical necessity for the continuity of care after the treatment authorization request is received.
 - D. In the communication log, Member Services will confirm eligibility effective date and document that the enrollee and/or non-contracted provider were advised to submit a treatment authorization form (TAR) to the Plan's UM department for the services being requested. The medical necessity for the continuity of care will be reviewed according to the UM process after receipt of the TAR.
3. The UM process will be utilized which includes communication of all decisions 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 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.

REFERENCES:

AB 1286/SB 244

28 CCR 1300.51(d) (H) (i), (ii) & (iv), 1300.67.2 (a) 7 (d), 1300.67.2.1 (a), 1373.96

RELATED POLICIES:

Continuity of Care by a Terminated Provider

APPLICATIONS:

All Plan EOCs

New Enrollee Welcome Letter

QACMP, Policy included by reference

COMMITTEE REVIEWS/APPROVAL:

| COMMITTEE | DATE |
|--------------------|---|
| P&T | 1/27/2005 |
| UM | 2/7/2005, 8/7/2008, 11/10/2011 |
| Standing Committee | 3/10/2005 |
| QA | 2/22/2005, 8/19/2008, 8/2009, 11/23/2011, 2/28/2012, 2/26/2013, 2/25/2014, 6/2/2015, 2/23/2016, 2/28/2017 |

CHANGE HISTORY

| Revision Date | Content Revised (Yes or No) | CONTRIBUTORS | REVIEW/REVISION NOTES |
|----------------------|--|---------------------|--|
| 01/27/2017 | No | Christina Turner | Updated to include Change History Page |
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