

**Administrative Policy:
Continuity of Care By A Terminated
Provider**

Effective: 06-01-00



VENTURA COUNTY
HEALTH CARE PLAN

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.

“**Block Transfer**” means a transfer or redirection of two thousand (2,000) or more enrollees by a plan from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract. **The Plan’s Compliance Officer must be made aware of any proposed Block Transfers, in order to complete the appropriate filing with the Department of Managed Health Care (DMHC).**

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 transfer 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, via the UR Nurse. Member Services will connect the Enrollee or the enrollee's Terminated Provider to a representative in UM for clarification and review of the Continuity of Care process. The UM representative will advise the enrollee and/or the enrollee's Terminated/non-

participating provider to submit a Treatment Authorization Request (TAR) to the UM Department via fax for the services being requested. The UM representative will also contact the terminating provider and request to submit a TAR to the UM Department via fax. The CM nurse or designee will evaluate continuity of care for members who are in active course of treatment per workflow detailed in the Continuity of Care Program Description.

- 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), upon request.
 - c. Member Services will connect the Enrollee or the Terminated provider to a representative in UM for clarification and review of the Continuity of Care process. The UM representative will advise the enrollee and/or the enrollee’s Terminated/non-participating provider to submit a Treatment Authorization Request (TAR) to the UM Department via fax for the services being requested. The UM representative will also contact the terminating provider and request to submit a TAR to the UM Department via fax. The CM nurse or designee will evaluate continuity of care for members who are in active course of treatment per workflow detailed in the Continuity of Care Program Description.
 - d. In the communication log, Member Services will document the responses from the enrollee or the Terminated Provider concerning eligibility for continuity of care and code the logs with “continuity of care”. Additionally, Member Services will document that the Enrollee or the Terminated Provider was connected to a representative in UM for clarification and review of the Continuity of Care process.
5. The Health Services Team coordinates the review and continuity of care process. All decisions will be communicated in writing to the enrollee and the Provider involved in the enrollee’s care through the **treatment authorization review (TAR) process**. 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.
 - g. a maternal mental health condition that impacts a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
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 re-assigned 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 (Geo-Access) 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 an 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.

ATTACHMENTS:

- Provider Group Termination Notice Letter Template
- Recontracted Provider/Group Notice Letter Template
- Provider Termination Notice Letter Template
- Hospital Provider Termination Notice Letter Template

RELATED POLICIES:

Continuity of Care for a New Enrollee

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

APPLICATIONS:

All Plan EOCs

Provider Agreements

QACMP, Policy included by reference

Notice Letter Template

COMMITTEE REVIEWS/APPROVAL:

COMMITTEE	DATE
P&T	1/27/2005
UM	2/7/2005, 11/10/2011
Standing Committee	3/10/2005
QA	2/22/2005, 8/19/2008, 9/2009, 11/12/2011, 2/28/2012, 2/26/2013, 2/25/2014, 6/2/2015, 2/23/2016, 2/28/2017, 2/27/2018, 2/26/2019, 2/25/2020, 2/23/2021, 2/22/2022

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
12/28/2017	No	Christina Turner	Added QA Review Date of 2/27/2018
01/17/2019	No	Christina Turner	Added QA Review Date of 2/26/2019
01/31/2020	Yes	Christina Turner	Updated to include Maternal Mental Health as a qualifying condition.
12/03/2020	No	Christina Woods	Added QA Review Date of 2/23/2021
12/16/2021	No	Christina Woods	Added QA Review Date of 2/22/2022