Policy and Procedures
Operating Manual

Policy Title:	*Continuity of Care - Commercial*	**Policy No.:**	*UM 42.0*
Replaces Policy Title *(if applicable)*		**Replaces Policy No.** *(if applicable)*	**COM 5103**
Department Owner	*Utilization Management*	**Policy Review Frequency:**	
Department Applicability	Contracts, Member Services, Utilization Management, Provider Relations		
Lines of Business *(check all that apply)*	☒ Commercial ☐ Medi-Cal ☒ Covered CA ☒ IFP		
Accreditations *(check all that apply)*	☐NCQA	☐AAAHC	☐ _____

I. POLICY

Valley Health Plan (VHP) is responsible for assuring the Continuity of Care (COC) for its members such that services are not interrupted for newly enrolled members who have been receiving services from a non-participating provider. COC is also provided to members whose provider may terminate after a relationship of care has already been established between the provider and member.

II. PURPOSE

The purpose of this policy is to ensure Valley Health Plan (VHP) provides Continuity of Care and Continued Access to Care to ensure a smooth transition to a new provider, to complete a course of treatment of eligible condition (s) with the same provider, or to maintain the same provider under certain circumstances as described under this policy.

III. DEFINITIONS

Block Transfer A transfer or redirection of two thousand (2,000) or more members 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.

Covered Services are medically necessary health care services, supplies, and benefits which members are entitled to receive under their line of business, as defined by applicable law and regulation, VHP's provider contracts, member evidence of coverage (EOCs), or member handbook.

Member Transfer Notice A written notice that is sent to members who are assigned to a Terminated Provider group or Terminated Hospital.

Individual Provider A person who is a licentiate, as defined in Section 805 of the Business and Professions **Code**, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions **Code**.

Letter of Agreement (LOA) Letter of agreement established between VHP and a non-contracted provider to provide services on an ad-hoc basis to VHP members for mutually agreed upon rates.

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.

Member A VHP beneficiary.

Non-participating Provider Is a provider who is not contracted with the member's health care service plan to provide services under the member's plan contract.

Primary Care Physician (PCP) VHP Physician/practitioner contracted with VHP to deliver primary care services to members. The PCP is responsible for the member's routine care and coordinating all of the medical services for that member.

Provider Contract A contract between a plan and one or more health care providers, through which the plan arranges to provide health care services for its members.

Provider Group A medical group, independent practice association, or any other similar organization providing services to VHP members who are assigned to that provider group.

Terminated Hospital A general acute care hospital that will no longer maintain a Provider Contract with VHP following the termination or non-renewal of a Provider Contract.

Terminated Provider Either a Terminated Provider Group or a Terminated Hospital.

Terminated Provider Group A Provider Group that will no longer maintain a Provider Contract with VHP following the termination or non-renewal of a Provider Contract.

VHP Administration Includes Chief Medical Officer, Medical Director, Associate Medical Director, Department Directors/Managers/Supervisors responsible for overall management of VHP and compliance with regulatory requirements.

IV. RESPONSIBILITIES

A. *Member Services Department (MSD)*

1. Receives request from the member for continuation of care with terminated/non-participating provider.
2. Logs member contact/request in Health Plan System and communicates to UM Department.
3. If the termination is for a PCP and a Block Transfer is required, MDS will send affected members a Members Transfer Notice at least 60 days prior to the termination or non-renewal of a Provider Contract and reassign the member to new PCP (MS 2.0).

4. Notifies member of UM determination per request.
5. If indicated, informs the member of the un-successful or successful Agreement for Services with the Terminated/Non-participating Provider and the new approval with the participating provider.

B. *Terminated/Non-Participating Provider*

1. Submits request for services to Utilization Management Department (UMD) timely with complete supporting clinical documentation for review.

C. *Utilization Management Department*

1. Receives request from MSD for preliminary review of services being considered as COC with terminated or non-participating provider.
2. Enters COC request and submitted supporting clinical documentation into VHP Authorization system, including an LOA request.
3. Reviews medically necessary treatment based on the approved utilization review guidelines and documents appropriateness for consideration under the COC policy.
4. The request is sent to the assigned Medical Director to review based on medical necessity with COC and make final determination.
5. Notifications will be issued/sent as follow:
    a. If the requested service is not a covered benefit or does not meet medical criteria: a denial letter with Member rights and appeal information is issued and sent to the member and the requested provider.
    b. If the requested service is a covered benefit and meets the medical criteria but does not meet the COC criteria: the requested service will be redirected and approved to a Plan provider. A Denial letter will be issued and mailed to the requested provider and the member. A Notification of approved service to the participating provider will be issued and sent to the Plan provider and the member.
    c. If the requested service is a covered benefit, meets the medical criteria and the COC criteria: The requested provider and the member will receive the Notification that the service is approved.
    d. If the LOA is unsuccessful and the member receives the service(s) VHP will pay for such services delivered in accordance with VHP's reasonable and customary payment policy.
6. Assigns the authorization to Contracts Manager to process an agreement for services with the Terminated/Non-participating Provider.
7. Communicates the determination back to MSD as needed.
8. If an agreement for services with the Terminated/Non-participating Provider is not successful, UMD contacts the referring provider, member's PCP, or member to request a different provider who is able to provide the same service(s).

D. *Contracts Manager*

1. Contacts the terminated/non-participating provider and attempts to complete a Letter of Agreement for Services.
    a. If successful, the process is complete.
    b. If not, Contract Team will document in VHP Authorization system and notify UMD.

E. *Case Management (CM)*

1. Case Management may assist member in identifying and transitioning to a new contracted provider.

V.PROCEDURES

1. In order to provide continuity of care for members and in accordance with California Health & Safety Code 1373.96, VHP provides the completion of covered, medically necessary services by a terminated provider or by a non-participating provider as described below:
    a. The completion of covered services shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services from that provider for one of the eligible conditions.
    b. The completion of covered services shall be provided by a non-participating provider to a newly covered member who, at the time his or her coverage became effective, was receiving services from that provider for one of the eligible conditions.
2. VHP will provide Completion of Covered Services for members with Eligible Conditions and Services per Health & Safety Code, § 1373.96 as follows:
    a. An acute condition. 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. An acute condition includes mental health/substance use disorder conditions.
    b. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or disorder that is serious in nature and that persists without full cure or worsens over an extended period 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 VHP in consultation with the member and the terminated or 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 or 12 months from the effective date of coverage for a newly covered member. A serious chronic condition includes mental health/substance use disorder conditions.
    c. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services will be provided for the duration of the pregnancy and the postpartum period.
    d. A terminal illness. 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 the terminal illness. The terminal illness of the member may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new member.
    e. Care of a child from birth to 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered member.
    f. Surgery or other procedure. 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 from the date of

the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.

g. Maternal Health. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

3. VHP will provide COC services for new enrollees in individual products only under the circumstances described below.:
    a. The newly covered individual member's prior coverage was terminated when a health benefit plan is withdrawn from any portion of a market, AND
    b. At the time the individual's coverage became effective, the newly covered member was receiving services from that provider for one of the eligible conditions.
4. Except as outlined in the above section 3, VHP does not provide continuity of care for services 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.
5. Contractual Considerations
    a. VHP may require the terminated provider whose services are continued beyond the contract termination date to agree in writing to the same contractual terms and conditions that were imposed upon the provider prior to 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, the plan is not required to continue the provider's services beyond the contract termination date.
    b. Unless otherwise agreed upon by the terminated provider and VHP or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by VHP 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 provider. Neither VHP nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.
    c. VHP may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered member 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, VHP is not required to continue the provider's services.
    d. Unless otherwise agreed upon by the nonparticipating provider and VHP or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by VHP 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 nonparticipating provider. Neither VHP nor the provider group is required to continue

the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

e. 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 VHP.

6. VHP considers a COC request is completed when:
    a. VHP notifies the member, in the manner outlined above, that the request has been approved.
    b. VHP and the non-participating provider are unable to agree to a rate.
    c. VHP will not provide completion of covered services by a provider whose contract with the Plan has been terminated or not renewed due to aspects of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    d. VHP does not provide continuity of care if the terminated provider was terminated for medical disciplinary cause or criminal activity.
7. After the COC Process is Completed:
    a. If VHP and the non-participating provider are unable to reach an agreement because they cannot agree to a rate, VHP will offer the member an in-network alternative. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to file a grievance.
    b. If a provider meets all of the necessary requirements, including entering into a letter of agreement or contract with VHP, VHP will allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with VHP for a shorter timeframe. In this case, VHP must allow the member to have access to that provider for the shorter period of time.
    c. At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, VHP will work with the provider to establish a care plan for the member.
8. Terminating Providers: When a provider group or hospital terminates its contract, VHP takes the following steps to transfer the members to another participating provider group or hospital:
    a. Provider Relations will immediately notify VHP Administration, Member Services, Utilization Management Department.
    b. For block transfers, the plan provides a 75-days written notice to the CA department of Managed Health Care in advance of the termination date. The notice includes a form of the written notice that the plan intends to send the Affected Members.
    c. Member services will notify members if the termination involves a Primary Care Physician. If a Block Transfer is required, Member Services will send Affected Members an Members Transfer notice meeting the standards at least 60 days prior to the termination or non-renewal of a Provider Contract.
    d. Utilization Management will conduct an open authorization report if the terminated provider and/or practitioner Contract is a Specialist, hospital, outpatient, and/or ancillary provider.

e. Provider Relations will follow up with each department within 15 days to ensure that Affected Members have been notified and the department has followed all applicable termination policies in their respective departments.
f. Provider Relations will terminate the provider and/or practitioner in all VHP databases and systems.
g. If the termination is due to the revocation of the practitioner's license, State and/or Regulatory sanctions, and/or medical disciplinary actions, VHP will not be obligated to provide Continuity of Care and Continued Access to Care.
h. Unless otherwise agreed upon between the terminated provider and/or practitioner and VHP, the agreement shall be construed to require a rate and method of payment to the terminated provider and/or practitioner for the services similar to currently contracted provider and/or practitioner who are not capitated and who are practicing in the same or similar geographic area as the terminated provider and/or practitioner. VHP or Provider Group shall not be obligated to continue the services of a Terminated Provider if the provider and/or practitioner does not accept the payment rates.

V. REFERENCES

- Senate Bill No. 133, 853m 855 and AB 577
- APL 20-001 (OPL) Newly Enacted Statutes Impacting Health Plans
- Cal. Health & Safety Code §1373.65, 1373.95 & 1373.96
- MS 2.0 Primary Care Physician (PCP) Assignments for VHP Commercial Members
- MS 9.0 Grievance Procedure
- UM 25.0 Review Criteria and Decision- Making Process
- UM 10.0 Processing of Authorizations, "Turnaround Time"
- PC 2.0 Provider Contract Administrative Management (LOA)
- UM 10.0 Authorization Process Timeline
- VHP Evidence of Coverage/Disclosure Form

VI. APPROVED/REVISION HISTORY

Original Effective Date:	3/25/2004	**Last Reviewed or Revised Date:**	12/2019, 9/2022, 10/2023, 11/2023
Approved By Manager:		**Title:**	
Manager Signature:		**Date:**	
Approved By Department Executive:		**Title:**	
Department Executive Signature:		**Date:**	
Committee Reviewed By (if applicable):	☒ UM ☐ P&T ☐ QIC	**Approved Date:**	9/13/2022

	☐Compliance ☐ QM_____		
Committee Chair Name			