Community Care Health
Continuity of Care Policy

Policy: 2.03a
Origination Date: 02/2016
Last Review Date: 02/2016
Revised: January 1, 2020

Purpose:

To ensure continuity of care (COC) for Community Care Health (CCH) Members when:

- Their Primary Medical Group (PMG), Independent Physician Association (IPA), individual physician or hospital is terminated from CCH's provider network or;
- They are a new Member in CCH (except newly covered Members who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans) and their treating provider is not part of the CCH provider network.

Scope:

Under certain circumstances, Members of CCH may be able to continue receiving services from Non-Participating/Terminating Providers.

COC assistance is intended to facilitate the smooth transition in medical care across health care delivery systems for new Members who are undergoing a course of treatment when the Member or the Member's employer changes health plans during open enrollment or when the Member is undergoing a course of treatment and the Member's treating provider is terminated from the CCH provider network.

The length of the transition period will be determined on a case by case basis taking into consideration the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. Reasonable consideration is given to the potential clinical effect of a change of providers on the Member's condition. Completion of covered services by a provider whose contract has been terminated or not renewed for reasons related to medical disciplinary cause or reason, fraud or other criminal activity will not be facilitated.

CCH must comply with applicable State law and regulations regarding provider terminations as outlined herein.

Policy:

For a Member to continue receiving care from a Non-Participating/Terminating Provider, the following conditions must be met:

1. COC services from Non-Participating/Terminating Provider must be Preauthorized by CCH;

2. The requested treatment must be a Covered Service under this Plan;

3. The Non-Participating/Terminating Provider must agree in writing to meet the same contractual terms and conditions that are imposed upon CCH's Participating Providers, including locations within CCH's Service Area, payment methodologies and non-capitated rates of payment.

Covered Services for the COC condition under treatment by the Non-Participating/Terminating Provider will be considered complete when:

1. The Member's course of treatment is complete; or

2. The Member's COC condition under treatment is medically stable and there are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by CCH's Chief Medical Officer or his or her designee.

COC also applies to new CCH Members who are receiving Mental Health care services from a Non-Participating/Terminating Mental Health Provider at the time their coverage becomes effective. Members eligible for continuity of mental health care services may continue to receive mental health services from a Non- Plan Provider for a reasonable period of time to safely transition care to a Mental Health Participating Provider. A Non-Participating Mental Health Provider means a psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker who has not entered into a written agreement with the network of Providers from whom the Member is entitled to receive Covered Services.

COC Condition(s) – The completion of Covered Services may be provided by: (i) a terminated Provider to a Member who, at the time of the Participating Provider's contract Termination, was receiving Covered Services from that Participating Provider, or (ii) Non-Participating/Terminating Provider for a newly enrolled Member who, at the time his or her coverage became effective with CCH, was receiving Covered Services from the Non-Participating/Terminating Provider, for one of the COC Conditions, as limited and described below:

1. An Acute Condition – A medical condition, including medical and Mental Health 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 will be provided for the duration of the Acute Condition.

2. A Serious Chronic Condition – A medical condition due to disease, illness, or other medical or mental health problem or medical or mental health 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 will be provided for the

period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Participating Provider, as determined by CCH's Chief Medical Officer or his or her designee in consultation with the Member, and either (i) the Terminated Provider or (ii) the Non-Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's Termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.

3. A Pregnancy diagnosed and documented by (i) the Terminated Provider prior to Termination of the agreement, or (ii) by the Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with CCH. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period. In addition, for maternal mental health conditions diagnosed and documented by a Terminating/Non-Participating Provider, completion of covered services for the maternal health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

4. A Terminal Illness – An incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services will be provided for the duration of the Terminal Illness, which may exceed twelve (12) months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

5. Surgery or Other Procedure – Performance of a Surgery or Other Procedure that has been authorized by CCH or the Member's assigned Participating Provider as part of a documented course of treatment and has been recommended and documented by the: (i) Terminating Provider to occur within 180 calendar days of the agreement's Termination date, or (ii) Non-Participating Provider to occur within 180 calendar days of the newly enrolled Member's effective date of coverage with CCH.

6. Care for Child who is a Newborn to 36 Months of Age – Care for a Member child who is a newborn to 36 months of age, not to exceed twelve months from the Member's effective date of coverage with CCH for newly enrolled Members, or twelve months from the agreement Termination date for Members receiving services from Terminated Providers.

Procedure:

Members may request COC by calling the Customer Service department number that is located on the back of their insurance card and requesting the form "Request for Continuity of Care". All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the newly enrolled Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

Forms must be submitted to CCH as soon as possible, but no later than thirty (30) calendar days of the Provider's effective date of Termination. Exceptions to the thirty (30)-calendar-day time frame will be considered for good cause. The address is:

Community Care Health
Attention: Continuity of Care Department
P.O. Box 45020
Fresno, CA 93718
Fax: 1-559-228-5460

CCH's Utilization Management department will complete a clinical review of a Continuity of Care request for the completion of Covered Services with a Non-Participating/ Terminating Provider and the decision will be made and communicated in a timely manner appropriate to the nature of the member's medical condition. In most instances, decisions for non-urgent requests will be made within five (5) business days of CCH's receipt of the completed form. Member will be notified of the decision by telephone and provided with a plan for their continued care. Written notification of the decision and plan of care will be sent to the member, by United States mail, within two (2) business days of making the decision. If the request for continued care with a Non-Participating/ Terminated Provider is denied, the member may appeal the decision.

Members who have any questions, or would like a description of CCH's continuity of care process, or want to appeal a denial, can contact our Customer Service department.

Please Note: It's not enough for a member to simply prefer receiving treatment from a Non-Participating/Terminated Provider. The member should not continue care with a Non-Participating/Terminated Provider without formal approval. If Preauthorization is not received by CCH, payment for routine services performed from a Non-Participating/Terminated Provider will be member responsibility.

ATTACHMENT:

- Community Care Health Continuity of Care Request Form

Community Care Health Continuity of Care Request Form

See instruction for completing this form on the reverse side.

*****ATTENTION: You may not need to complete this form*****

> **Complete this form only if you are utilizing a non-participating health care professional. Please check your Community Care Health (CCH) provider directory or check the CCH website (www.communitycarehealth.org) to confirm that your doctor is in the CCH network.**

> See reverse for instruction to complete this Continuity of Care Request Form.

> Use a separate form for each condition. Photocopies are acceptable. Attach additional information if necessary.

Employer	Policy #	Employee Date of Enrollment in CCH Benefit Plan (mm/dd/yyyy)
Employee Name	Employee Social Security #	Work Phone
Home Address (Street, City, State Zip)		Home Phone

Patient's Name	Patient's Social Security #	Patient's Birthdate (mm/dd/yyyy)	Relationship to Employee □Spouse □Dependent □Self

1. Is the patient pregnant? □ Yes □ No
2. If yes, when is the due date?_____(mm/dd/yyyy)
3. Is the patient currently receiving treatment for an acute condition or trauma? □ Yes □ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with CCH? □ Yes □ No
5. Is the patient involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy or candidate for Organ Transplant? □ Yes □ No
6. Is the patient receiving treatment as a result of a recent major surgery? □ Yes □ No
7. Is the patient receiving mental health/substance abuse care? □ Yes □ No
8. Is the patient receiving care for a terminal illness? □ Yes □ No
9. If you did not answer "Yes" to any of the above questions, please described the condition for which the patient requests Continuity of Care.

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10. Please complete the provider information below.

Group Practice Name		
Doctor's Name	Telephone # of Provider	
Doctor's Specialty		
Doctor's Address		
Hospital Where Patient's Doctor Practices	Telephone # of Hospital	
Hospital Address		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

11. Is this patient expected to be in the hospital when or after coverage with CCH begins? □ Yes □ No
12. Please list any other continuing care needs that may qualify for Continuity of Care benefits
    If these are not related to the condition for which you are applying for Continuity of Care benefits, you must complete a separate Continuity of Care Form.

I hereby authorize the above physician to provide CCH or any affiliated CCH company with any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care Benefits under CCH. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

INSTRUCTIONS FOR COMPLETING CONTINUITY OF CARE REQUEST FORM

A separate Continuity of Care Request Form must be completed for each condition for which you and/or your dependents are seeking Continuity of Care benefits. Please make certain that all questions are completely answered. When the form is completed, it must be signed by the patient for whom the Continuity of Care benefits have been requested. If patient is a minor, a guardian's signature is necessary.

The first few sections of the form apply to the Employee. When the form asks for the patient's name, only the name of the person who is actually undergoing care and is requesting Continuity of Care, should be reflected. Please submit this Continuity of Care Request Form to:

Community Care Health
P. O. Box 45020
Fresno, CA 93718

In #8, include information about your current or proposed treatment plan and the length of time your treatment is expected to continue. If surgery has been planned, state the type and the proposed date of your surgery.

In #11, briefly state the health condition, when it began and what provider is currently involved? How often do you see this provider?

To help ensure a timely review of your Continuity case, please return the form as soon as possible. You must apply for Continuity of Care benefits within 30 days of the provider's termination date. The completed forms should be marked "Confidential" and forwarded to the Healthcare Facilitation Center address above. CCH will notify you in writing of the approval or denial of your request.