POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Continuity and Coordination of Services
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APPROVED DATE: 9/29/14	**RETIRED:** CC.UM.19
EFFECTIVE DATE: 9/29/14	**REVIEWED/REVISED**: 08/15; 08/2016; 7/17; 7/18; 3/19
PRODUCT TYPE: Medicaid, HIM, Medicare	**REFERENCE NUMBER:** CC.UM.20

SCOPE:
Medical Management Department

PURPOSE:
To describe the process for ensuring members have access to appropriate network, and in special circumstances non-network, providers to promote continuity of care.

POLICY:
Coordination of care encompasses synchronization of medical, social, and financial services and may include management across payer sources to promote continuity of care. The health plan ensures appropriate referrals and linkages are made for members to applicable provider or community resources, even if these services are outside of the required core benefits of the health plan, are not available in the health plan network, or the member has met the benefit limitation. This includes sharing member information, especially those members with special health care needs, with other insurance payers in accordance with federal, state and/or regulatory or accreditation guidelines. In addition, the health plan assists new providers in obtaining member medical records as appropriate and in compliance with federal and state law. Throughout this process, the health plan ensures member privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable.

The health plan coordinates transitions of care in circumstances impacting members and their care plan, e.g. when benefits end, when a member transitions from pediatric to adult care or terminates with the health plan, etc. The health plan makes the transition of care policy publically available, via the member handbook, member website, and/or other member materials, and provides instructions to members and potential members on how to access continued services upon transition.

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PROCEDURE:

1. *Maintaining Privacy*
   Health plans ensure member privacy is protected during all communications with external parties. Transfer of protected health information (PHI) is conducted by phone, secure fax, or secure email in order to ensure maintenance of member privacy at all times. Only the minimal necessary information is shared.

2. *New Member Enrollment to Health Plan*
   The health plan assures continued and consistent access to services during a transition from another payer source (e.g. fee-for-service (FFS) Medicaid or Medicare), or another health plan. The health plan may identify members receiving an active course of treatment or services at the time of their enrollment via historical claims data (if available), health risk screenings or assessments, or upon a member or provider request for continued authorization. The health plan ensures appropriate referrals and linkages are made for the member to continue receiving all necessary treatment and services.

   In the event a member entering the health plan is receiving medically necessary covered services, the health plan honors a transition period for continuation/coordination of such services ***based on plan or contracted requirements***, including providers not participating in the health plan network. Prior authorization requirements may apply. The member is referred to a participating provider as soon as appropriate, based on the transition plan.

3. *Care Transition - Termination from the Health Plan*
   For members in active care transitioning out of the health plan, the health plan communicates active services to the receiving entity, upon request. The health plan complies with all requests for historical utilization data in a timely manner, in compliance with state and federal requirements.

4. *Coordination of Care When a Member Exhausts a Benefit*
   The health plan assist members with accessing alternatives for continuing care if a member's covered benefits are exhausted or the member has met a benefit limitation (e.g. monthly cap on medical supplies) and care is still needed. The health plan maintains a list of benefits that have annual or other timeframe limitations. This list is updated as benefits are modified by the State or Centers for Medicare and Medicaid Services (CMS), and reviewed at least annually.
   a) Requests that cannot be granted due to benefit limitations are identified during requests for extension of a previously approved service, or upon inquiry from a member or servicing/treating provider.
   b) For requests received for additional services, the prior authorization nurse refers the request to a Medical Director for a determination.
   c) If the Medical Director denies the request, the health plan attempts to contact the member telephonically and assist the member in identifying available resources within the local community.
      - A care manager discusses with the member alternative care and resources available to the member.
      - The care manager makes at least three (3) telephonic outreach attempts to contact the member. If unable to reach the member, a letter is sent to the member stating multiple outreach attempts have been made and requests they contact the health plan. This process occurs within a two (2) week timeframe.
      - All attempts and discussion are documented in the member's clinical documentation system record.
      - Requests for assistance in identifying additional resources are forwarded directly to the Care Management Department.

5. *Transition from Pediatric to Adult Care*
   The health plan assists members with transition from pediatric care to an adult care provider in collaboration with the pediatric practitioner, as applicable. The health plan encourages the member to discusses the transition with their pediatric care provider and determine a transition plan that is appropriate for each individual. Members may continue to

see pediatric care providers after they are adults, if the provider agrees, but a transition plan is expected.

a) The health plan notifies members who are reaching adulthood of available assistance with choosing an adult practitioner (*age of adulthood may vary per state regulation*). Member notification occurs through the member newsletter or other appropriate member communication. The notification advises of the importance of receiving care by an age appropriate practitioner and encourages the member to speak with their current specialist or primary care provider for guidance and referrals.
b) The notification also provides contact information for assistance with a referral by the health plan if needed.

6. *Practitioner/Provider Termination*

Members are notified of a termination of their assigned primary care provider (PCP) from the health plan network at least 30 days (or per state contract requirement if more stringent) prior to the effective termination date. If the practitioner or group notifies the health plan of the termination less than 30 calendar days prior to the effective date, the health plan notifies members as soon as possible, but no later than 30 calendar days (or per state contract requirement if more stringent) after receipt of the notification.

Members in active treatment for a chronic or acute medical condition are also be notified of a practitioner termination. Continuation of care with the terminated provider is allowed under certain circumstances if the provider is not termed due to a quality issue.

a) For members in active treatment for a chronic or acute medical condition, the health plan allows continuation of such services for up to 90 calendar days, through the current period of active treatment, or until the member is reasonably transferred to a network provider without interruption of care, whichever is less (or as required by contract).
b) For members in their second or third trimester of pregnancy, the health plan provides continued access to the practitioner through the post-partum period.

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REFERENCES
42 CFR §438.62
NCQA Health Plan Accreditation Standards and Guidelines

ATTACHMENTS:

DEFINITIONS:

REVISION LOG	**DATE**
Annual review; no substantive changes to content	08/2015
Annual review: Minor changes to #5; detail added to #6; NCQA updated to reflect current; updated approver titles; no substantive content change.	08/2016
Added detail regarding continued services to enrollees, per 42 CFR §438.62; noted in the policy statement that the transition of care policy is made available in the member handbook, etc.; added detail to sections 4 and 5 that was previously covered in policy CC.QI.09; removed section 5 (c) – "The Plan documents all calls received requesting assistance in the clinical documentation system record with the call type "Pedi Adult Transition" as this call type is not available to all plans in TruCare and is not required.	07/2017
Annual review, no changes other than clarifying policy also applies to the Marketplace product.	07/2018
Added "Medicare" to product line of business, revised the previous *Purpose* statement from **"***To describe the process for ensuring that appropriate referrals and linkages are made for the member including covered and non-covered services while maintaining the member's privacy***"** to **"***To describe the process for ensuring members have access to appropriate network, and in special circumstances non-network, providers to promote continuity of care.***"** Deleted **"***The decision process will adhere to the utilization management policy and procedure CC.UM.05, Timeliness of UM Decisions and Notifications or applicable Medicare policy"* from section 4b) Coordination of Care When a Member Exhausts a Benefit. No other substantive changes.	03/2019

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in the P&P management software is considered equivalent to a physical signature.

Director, Accreditation, Quality Improvement: Signature on File
Director, Medical Management: Signature on File