

CONTINUITY OF CARE PROGRAM DESCRIPTION

Program Description

Medical Director Approval



Medical Director Signature

2/26/25
Approval Date

Administrator Approval



Administrator Signature

2/26/25
Approval Date

Credentialing Committee Approval



Chairperson Signature

1/13/25
Approval Date

Pharmacy and Therapeutics Committee Approval



Chairperson Signature

2/18/25
Approval Date

Utilization Management Committee Approval



Chairperson Signature

2/20/25
Approval Date

Quality Assurance Committee Approval



Chairperson Signature

2/25/25
Approval Date

Standing Committee Approval



Chairperson Signature

3/13/25
Approval Date

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CONTINUITY OF CARE PROGRAM DESCRIPTION

Purpose and Scope

The **Purpose** of the Continuity of Care program established within the VCHCP for the enrollees is designed to ensure proper transitions of care for the enrollees between levels of services administered, service providers and throughout the spectrum of life's stages. This continuity will be ensured through primary care, specialty care, acute care, rehabilitation, hospice, home care, behavioral health services and ancillary services such as physical therapy and occupational therapy. Continuity also applies to tests and procedures performed in the course of treatment.

Coordination may occur through established documents transmitted between providers, through telephonic communication and electronic communication. This applies with all levels of services, including but not limited to coordination between behavioral health services and primary care.

Oversight of the evidence of the communication / coordination between providers as demonstrated through the utilization of the tools occurs during the annual delegation oversight audits of delegated entities and during chart review performed by the Plan.

The **Scope** of the VCHCP's Program Description is three-fold:

1. **The Medical Home**: To provide for the Coordinating the provision of health care services to each enrollee. This will include encouraging each enrollee to select a primary care physician (PCP), the maintenance and readily available access to medical records, and ensuring an adequate system of documentation to the physicians. An adequate network of physicians will be made available to the enrollees to ensure regulatory access and availability for urgent, routine and preventive health care.
2. **The New Enrollee**: 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 of the enrollee's treatment caused by the change in Provider.
3. **By the Terminated Provider**: 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 for any Provider 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 of the enrollee's treatment caused by the change in Provider.

Inquiries to the Plan will be tracked and reported quarterly to the Member/Provider Experience Committee (MPEC). Member Services has a field in their call tracking system (Call Type: Cont of Care) and the Utilization Management Team has a field in their Treatment Authorization Requests (TAR) to indicate Continuity of Care.

The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network. The organization uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.

Continued Access to Practitioners

If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows:

1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.
2. Continuation of care during duration of pregnancy through the postpartum period.

Continued access applies only if the practitioner agrees to the following:

- To continue the member's treatment for an appropriate period of time (based on transition plan goals).
- To share information regarding the treatment plan with the VCHCP.
- To continue to follow VCHCP UM policies and procedures.
- To no charge the member an amount beyond a required copayment.

This applies to Block Transfers as well. 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).

Procedures for ensuring continuity of care:

1. Member/Provider Services (M/P S) (Attachment 1 - M/P Flow Chart)

- M/P S is notified of a provider termination.
- M/P S contacts the departing Physician's office to collaborate with the office and gather certain administrative/non-clinical information.
- M/P S generates a list from the claims payment system of members:
 - Assigned to the terming PCP
 - Assigned to a clinic where the terming PCP is practicing and has been seen by that PCP in the last 12 months
 - Has been seen by the terming Specialist in the past 12 months.
- For PCP terminations, M/P S mails a letter to the impacted members at least 60 calendar days prior to the effective termination date with date of departure and instructions for changing PCP. If the PCP notifies VCHCP of termination less than 60 calendar days prior to the effective date, M/P S notifies the affected members as soon as possible, but no later than 30 calendar days after receipt of the notification.
- For non-PCP terminations, M/P S mails a letter to the impacted members at least 60 calendar days prior to the effective termination date with date of departure. The letter also provides notice that the member "may" have the opportunity for continuity of care should they meet certain requirements, and to contact M/P S for more information. If the non-PCP notifies VCHCP of termination less than 60 calendar days prior to the effective date, M/P S notifies the affected members as soon as possible, but no later than 30 calendar days after receipt of the notification.
- For Provider Group Block Transfers, M/P S mails a letter to the impacted members at least 60 calendar days prior to the effective termination date with date of departure and instructions for changing their PCP, if applicable. If VCHCP is unable to send out notification at least 60 calendar days prior to the effective date, the Plan's Compliance Officer will be notified, so that an application for waiver can be filed with the DMHC.
 - If the Plan reaches an agreement to renew or enter into a new Provider Contract or to not terminate the original contract after sending the initial notification to the members, an additional notification will be sent to the members notifying them of this and to advise them of their available options.
- For Hospital Block Transfers, M/P S mails a letter to members who reside within 15 miles of the Terminated Hospital at least 60 calendar days prior to the effective termination date with date of departure. If VCHCP is unable to send out notification at least 60 calendar days prior to the effective date, the Plan's Compliance Officer will be notified, so that an application for waiver can be filed with the DMHC.
- M/P S sends UM a copy of the letter, along with a list of impacted members.
- If member responds that they may be in an "active course of treatment", member is referred to UM for further assistance.

2. Health Services/Utilization Management (HS) (Attachment 2 – HS/UM Flow Chart) (Includes Block Transfer)

- HS receives from Member/Provider Services the list of members who are receiving the physician departure letter and those members who responded as being in the middle of treatment/eligible for continued access.
- HS reviews the complete list of members affected by the physician’s departure and drills down to identify members who are actually in the middle of treatment or eligible for continued access per “types of conditions and length of continuity of care guideline”
- The types of conditions and length of continuity care guidelines are: (1) acute condition such as pneumonia as long as condition lasts; (2) serious chronic condition such as severe diabetes or heart disease for no more than 12 months; (3) pregnancy- including full duration of pregnancy and after delivery/post-partum; (4) terminal illness for as long as the person lives; (5) care of children from birth to 3 years for up to 12 months; (5) already scheduled surgery or procedures such as knee surgery or colonoscopy to happen within 180 days of provider leaving the Health Plan or surgery or other procedure that has been authorized by the Plan as part of a documented course of treatment to occur within 180 days of provider leaving the Plan; (6) 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.
- HS obtains and analyzes claims data for member with multiple visits to provider.
- HS calls practitioner to find members in the middle of active treatment.
- HS uses utilization management (UM) data to find members in the middle of active treatment.
- HS uses case management (CM) and disease management (DM) data to find members in the middle of active treatment.
- UM or CM nurse works with the Plan’s medical director to coordinate continuity of care/active course of treatment with practitioners
- If member wishes to finish the treatment with the terminating practitioner, HS assists member to ensure continuity of care and provides temporary case management/continuity of care.
- If the member does not wish to finish the treatment with the terminating practitioner, HS assists the member to transition to a new practitioner and provides temporary case management/continuity of care.
- HS continues to authorize/manage the member through the current active treatment or for up to 90 calendar days whichever is less or no more than 12 months per the Department of Managed Health Care (DMHC)
- HS continues to authorize care through the full duration of the member’s pregnancy up to postpartum.
- HS authorizes already scheduled surgery or procedure scheduled to happen within 180 days of the practitioner leaving the Plan (DMHC).
- HS executes a case agreement with the practitioner and provides the Plan’s claims department a copy of the case agreement.
- HS shows evidence of coordination with practitioner such as case agreement, screen shot of UM or CM authorization/coordination of care and claims payment.

Supporting Policies

- Administrative Policy; Continuity of Care for a New Enrollee
- Administrative Policy; Continuity of Care by a Terminated Provider
- Utilization Management Policy; Continuity of Medical Care – Transition to Other Care When Member’s Benefit Ends
- Evidence of Coverage
- Provider Directory
- Provider’s Operations Manual

APPENDIX

A. **Attachments:** Attachment 1 - M/P Flow Chart
Attachment 2 – HS/UM Flow Chart) (Includes Block Transfer)

B. **References:** N/A

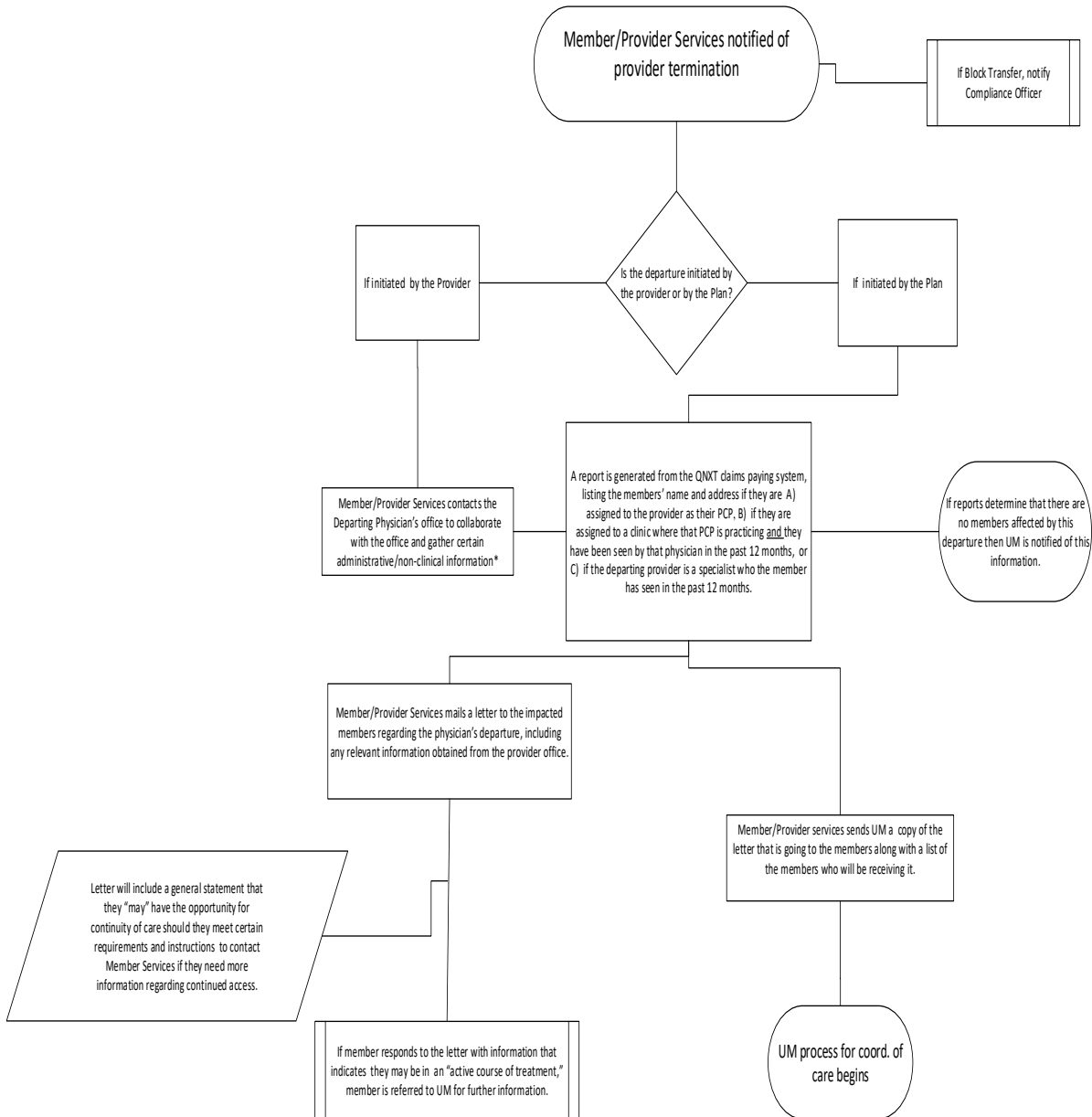
C. **Effective Date:** 5/27/2014

D. **Approvals:**

COMMITTEE	DATE
Quality Assurance Committee (QAC)	05/27/2014
Quality Assurance Committee (QAC)	02/24/2015
Quality Assurance Committee (QAC)	02/23/2016
Quality Assurance Committee (QAC)	02/28/2017
Quality Assurance Committee (QAC)	02/27/2018
Quality Assurance Committee (QAC)	02/26/2019
Quality Assurance Committee (QAC)	02/25/2020
Quality Assurance Committee (QAC)	02/23/2021
Quality Assurance Committee (QAC)	02/22/2022
Quality Assurance Committee (QAC)	02/07/2023
Quality Assurance Committee (QAC)	02/27/2024
Quality Assurance Committee (QAC)	02/25/2025

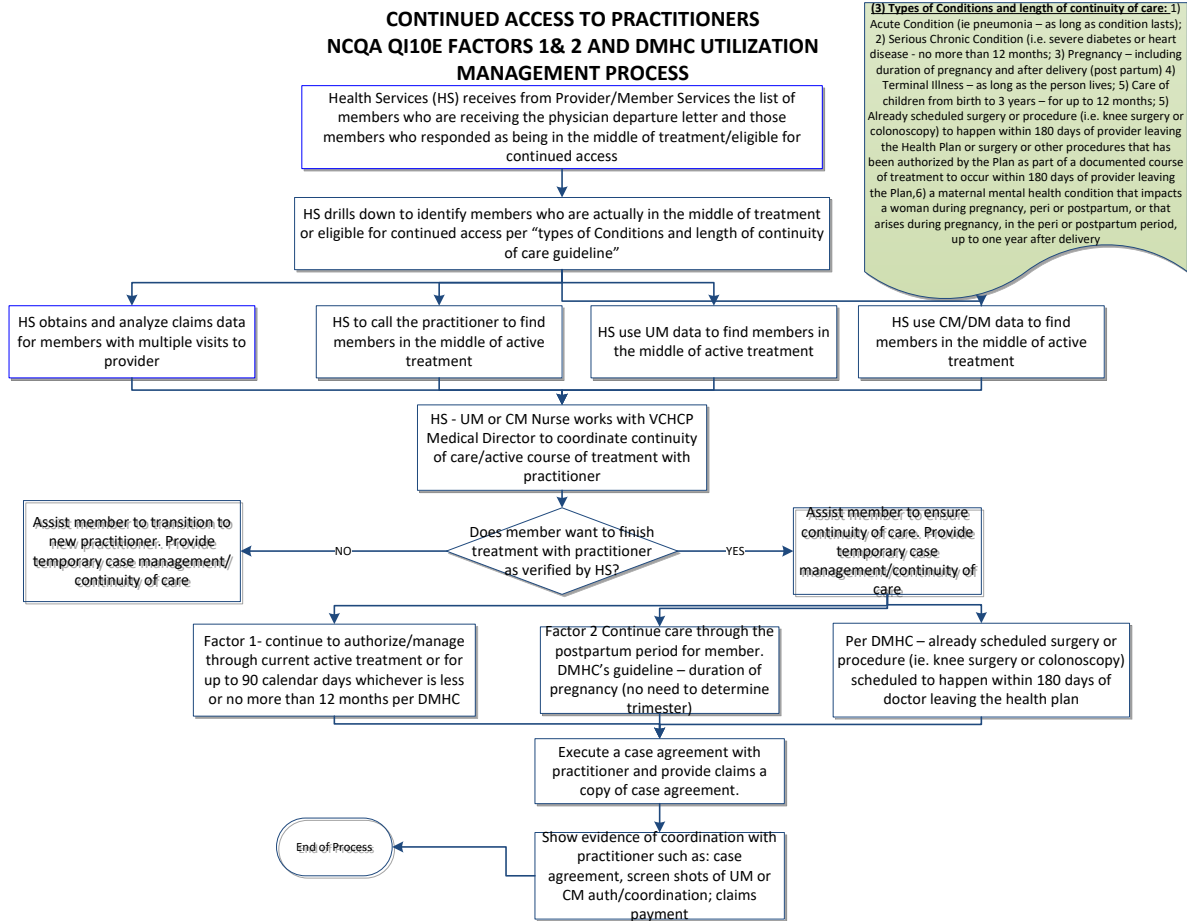
ATTACHMENT I

Member/Provider Services Flow Chart



ATTACHMENT II

Health Services/Utilization Management Flow Chart
(Includes Block Transfer)



Faustine Dela Cruz
Updated 01/31/2020

CHANGE HISTORY

Revision Date	Content Revised (Yes or No)	CONTRIBUTORS	REVIEW/REVISION NOTES
09/21/2016	No	Christina Turner	Updated template to include Change History Page
01/27/2017	Yes	Christina Turner Faustine DeLaCruz	Removed Transition from Pediatrics process Updated Supporting Policies section for QA and UM
12/29/2017	No	Christina Turner	Updated date to show 2018, and minor formatting changes.
01/17/2019	No	Christina Turner	Updated for 2019 and added QA Review Date of 2/26/2019.
01/31/2020	Yes	Christina Turner	Updated for 2020 and added Maternal Mental Health as a qualifying condition.
12/02/2020	No	Christina Woods	Updated date to show 2021
12/16/2021	No	Christina Woods	Updated to show 2022.
12/29/2022	No	Christina Woods	Updated to show 2023.
01/18/2024	No	Christina Woods	Updated to show 2024 and added effective date.
12/26/2024	No	Christina Woods	Updated to show 2025