Anthem Blue Cross Medicaid (Anthem Blue Cross Medicaid) maintains a policy to provide members with continuity of care under the following circumstances;

- Practitioners contract is terminated
- Physician Group contract is terminated
- Hospital contract is terminated

Anthem Medicaid allows members undergoing active treatment for chronic or acute medical and behavioral health conditions to have access to their discontinued practitioners through the current period of active treatment.

An “active course of treatment” is one in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.

The length of transition period is based on the severity of the enrollee’s condition and the amount of time reasonably necessary to affect a safe transfer within regulatory requirements. The determination of an appropriate transition period is made on a case-by-case basis and includes reasonable consideration of the effect of a provider change on the member’s medical treatment; however the transition/continuity of care period will not exceed 12 months.

PURPOSE:

This policy is designed to provide a procedure for transition of care or continuity of care assistance to Anthem Blue Cross Medicaid members with qualifying conditions when affected by the termination of a provider or practice site.

Qualifying Condition: The medical conditions that may qualify a member for Continued Access to Care/Continuity of Care may include, but are not limited to:

- An acute condition
- A serious chronic condition
- Pregnancy, regardless of trimester, through immediate postpartum care
- Terminal illness
- Care of a newborn child between the ages of birth and 36 months
- Surgery or other procedure authorized by Anthem Blue Cross Medicaid and is scheduled to occur within 180 days of the contract’s termination or within 180 days of the effective date of coverage for a newly covered enrollee
• Degenerative and disabling conditions (a condition or disease caused by a congenital or acquired injury or illness that requires a specialized rehabilitation program, or a high level of care, service, resources or continued coordination of care in the community)

SCOPE:

The scope of this policy applies to Anthem Blue Cross Medicaid members identified as needing transitional care or continuity of care assistance due to either of the following:

A. A Provider/Primary Care Physician change in his/her affiliation with a contracted physician group or termination of the contract with Anthem Blue Cross Medicaid.
B. The member’s benefits are exhausted (as in MRMIP).

It is the policy of Anthem Blue Cross Medicaid to assist providers and patients in terminating treatment or transitioning care to alternate resources such as community agencies.

DEFINITIONS:

Active Course of Treatment: An “active course of treatment” is one in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.

Acute Condition: A medical or behavioral health 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.

Continuity of Care: The process of authorizing continuation of services with a terminating or non-participating provider under specified conditions and for a limited period of time with a plan of care to transition the member to a network provider.

Serious Chronic Condition: A medical or behavioral health condition due to a disease, illness, or other medical problem or medical disorder that is complex in nature and that does either of the following:
• Persists without full cure or worsens over an extended period of time.
• Requires ongoing treatment to maintain remission or prevent deterioration.

PROCEDURE:

Case Intake: Anthem Blue Cross Medicaid members are notified of their right to request Continued Access to Care at the time of enrollment (through their Evidence of Coverage/Member Handbook) and when their provider terminates (through their member notification letter). Additionally, terminating providers may contact Anthem Blue Cross Medicaid to request Continued Access to Care/Transition Assistance on behalf of the member.
A CM/UM Nurse reviews all member/provider requests for Continuity of Care/Continued Access to Care to identify members who may qualify for Continued Access to Care.

Network Support will provide the Medical Management department with a list of all members impacted by the termination of a provider. The CM/UM Nurse will identify all members with an open care management case and will contact members in order to coordinate the member’s care, facilitating the transfer of records and other information to the new provider as necessary.

Members who contact CM/UM directly will be assisted by a CM/UM Nurse to ensure the transition to the new physician is successful or work with the current PCP/Specialist if the member is in a course of treatment for no longer than 12 months, and facilitate the course of treatment.

**Acknowledgement of Receipt of Request for Continued Access to Care:** The CM/UM department places and documents a telephone call to the requesting member or provider regarding their request for Continued Access to Care/Transition as follows:

- Acknowledge receipt of the request for assistance.
- Verify demographic information and scheduled date of service or delivery.
- Re-establish case priority based on new information or member’s expectation.
- Advise the member of the toll free Customer Care number.
- Inform the member of the Continued Access to Care process, and answering the member’s questions.

The CM/UM nurse will document all calls and outcomes on requests for Continued Access to Care/Transition Assistance. The CM/UM nurse will transfer the necessary documentation to the on-line system case.

**Applicability:** When an individual provider or PMG/IPA terminates its contract with Anthem Blue Cross Medicaid or is terminated by Anthem Blue Cross Medicaid, Anthem Blue Cross Medicaid notifies members of the impending termination and of their right to request Continued Access to Care/Transition Assistance. For hospital termination, Anthem Blue Cross Medicaid notifies members as soon as termination is known.

**Non-Applicability:** Anthem Blue Cross Medicaid is not required to authorize ongoing treatment with a provider when the provider’s termination is based on reasons relating to medical disciplinary cause or reason, as defined by California Business and Professions Code Section 805(a)(6), or fraud or other criminal activity.

For cases in which Continued Access to Care/Continuity of Care is deemed not applicable, the member’s transition plan is designed to assist the member with the selection of a new participating provider.
New Enrollee Information: Customer Care Center representatives may refer new enrollees requesting Continued Access to Care directly to the CM/UM department.

Assessment and Determination: CM/UM reviews and approves or denies all requests for Continued Access to Care. The request for Continued Access to Care/Transition Assistance is evaluated based on the individual patient’s clinical condition. Medical records or other information are requested when additional information is needed to make a determination.

Approval or denial for Continued Access to Care is made on the basis of the member’s specific clinical condition, medical needs, and circumstances. With the exception of maternity, the determination is not based on the member’s diagnosis.

If the CM/UM nurse cannot approve the request for clinical reasons, the request is referred to a Physician Reviewer for determination and recommendations.

The CM/UM nurse may determine that the member is not eligible for Continued Access to Care for non clinical reasons in the following instances:
- Treating physician is a contracted provider.
- Member withdraws the request.
- Request is for change of PCP only (refer to member services).
- Anthem Blue Cross Medicaid coverage not selected.
- Date of service prior to effective date with Anthem Blue Cross Medicaid.
- Course of treatment has been completed.
- Requested services are not a covered benefit with Anthem Blue Cross Medicaid.

The CM/UM nurse documents the transition to care process in the member’s in the case notes.

Notification: The CM/UM nurse promptly notifies the provider of Anthem Blue Cross Medicaid’s determination as to whether or not authorization for Continued Access to Care has been granted. Confirmation of an adverse determination is sent to the member within 2 business days of the determination.

Transition Care Plan: Only members approved for Continuity of Care can complete their current treatment plan with the terminating provider. Anthem Blue Cross Medicaid members who do not meet the eligibility requirements for continuing care with their present provider may seek assistance from Anthem Blue Cross Medicaid in selecting a participating provider. Anthem Blue Cross Medicaid will provide assistance in transitioning the patient to a participating provider. Continuity of Care 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.

The CM/UM nurse develops and documents a transition plan for members approved for continuity of care/transition assistance. Plan development includes contact with the member,
the treating provider, and the participating provider to whom the member’s care will be transferred, as appropriate.

The transition plan will include at minimum the following:

- The non-participating provider’s treatment plan for the member’s active course of treatment, for which Continuity of Care was requested.
- The specific treatment goal to be reached prior to transfer to the Blue Cross Medicaid contracting provider and the estimated date the transfer can be safely accomplished.

The CM/UM nurse documents the Continuity of Care plan and the member’s progress at intervals appropriate to the specific case. Referrals to appropriate Anthem Blue Cross Medicaid resources are included and documented in the transition plan.

Members with conditions/diagnoses for which Health Management and Education Programs are in place, are referred for screening, and if appropriate, risk stratification and program participation.

Provider questions about reimbursement rates outside of the Continuity of Care period are referred to Network Support.

**Case Closure:**

The member’s CM/UM case is closed when:

- The member’s condition is resolved and no further treatment for the specific condition is anticipated.
- The member’s postpartum visit indicates cessation of ongoing care.
- A request for Continuity of Care has been received with missing member information and or clinical information. Two attempts are made to reach the member and if no response, a deferral letter for lack of clinical information is generated for outpatient services.
- The member is transitioned to an in network provider for services.

**REFERENCES:**

Central Valley/Bay Area Contract 03-768184 A 11, Exhibit A, Attachment 11
Sacramento Contract07-65845, Exhibit A, Attachment 11
Stanislaus Contract 04-35797 A8, Exhibit A, Attachment 11
Tulare Contract 04-36068 A 07, Exhibit A, Attachment 11
Tri-County Fresno,Kings, Madera Contract 10-87053 Exhibit A, Attachment 11 Provider Operations Manual Version 1.4
Blue Cross of California Member Handbook
CA_PNXX_303: Provider Termination
California Assembly Bill 1286/California Senate Bill 244
California Health and Safety Code: Sections 1373.65, 1373.95 and 1373.96
SECTION
Care Management

Plans: Medi-Cal X
HlthyFam HMO X EPO X
MRMIP X AIM X

Policy Number: CA_CAXX_110

SUBJECT
Care Management/Transition Assistance/Continuity of Care

RESPONSIBLE DEPARTMENTS:
Medical Management; Utilization Management (UM) & Case Management (CM)
Network Support,

REVISION HISTORY:

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<th>Review Date</th>
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<tbody>
<tr>
<td>03/21/12</td>
<td>• Revised reasons for terming a contract.</td>
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