POLICY:

Anthem Medicaid (Anthem) is responsible for providing Access to Care/Continuity of Care and coordination of medically necessary medical and mental health services.

Members who are, or will be, receiving excluded services will be disenrolled from Anthem in order to be eligible for the services. Anthem is responsible for ensuring continuation and coordination of services until the member is disenrolled from the plan, unless stated otherwise.

This policy clarifies specific procedures and processes to be followed by Anthem in providing continued Access to Care/Continuity of Care, due to the unique nature of Anthem’s business (which includes Medi-Cal, Low Income Health Program members, Major Risk Medical Insurance Program (MRMIP), and Medical Access Program).

DEFINITIONS:

**Basic Case Management:** a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health need and provided by a collaborative effort between the Medical Management staff, the primary care provider and other professionals who have an active role in managing members’ health care condition and needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

**Care Coordination:** services which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.

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

**Low Income Health Program Member:** an Adult Expansion Member who was formerly a LIHP
The internal policies and procedures outlined herein are to be used for the Medicaid Business Unit

**Transition Assistance/Continuity of Care**

The following states are included where the policy applies:
- Arkansas
- California
- District of Columbia
- Florida
- Georgia
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maryland
- Minnesota
- Nevada
- New Jersey
- New York
- New York (WNY)
- South Carolina
- Tennessee
- Texas
- Virginia
- Washington
- Wisconsin
- West Virginia

The policy applies to Medicaid products offered by health plans operating in the following State(s):

**Medical Exemption Request (MER):** A request for medical exemption from enrollment into a managed care plan for up to 12 months, in order to complete a treatment with the beneficiary's current Medi-Cal FFS provider(s). This treatment must be for a complex medical condition, and must be provided by a physician, certified nurse midwife, or licensed midwife who is participating in FFS and is not contracted with any of the MCPs available in an eligible beneficiary's county of residence.

**Qualifying Conditions:** 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.** 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.

- **A serious chronic condition.** A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical 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 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 the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating 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 enrollee.

- **Pregnancy, regardless of trimester, through immediate postpartum care.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

- **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 a terminal illness, which may exceed 12 months from
The internal policies and procedures outlined herein are to be used for the Medicaid Business Unit

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the contract termination date or 12 months from the effective date of coverage for a new enrollee.

- Care of a newborn child between the ages of birth and 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 enrollee.

- Surgery or other procedure authorized by Anthem Medicaid and is scheduled to occur within 60 days of the contract’s termination or within 60 days of the effective date of coverage for a newly covered enrollee.

Risk of Harm: an imminent and serious threat to the health of the beneficiary.

PROCEDURE:

I. General Information

A. Anthem members are notified of their right to request continued Access to Care at the time of enrollment (through their Evidence of Coverage), whenever their provider terminates (through their member notification letter), or during a time of transition into Anthem from a Fee-for-Service (FFS) Medical program. Members, member advocates, caregivers, providers, or terminating providers may contact Anthem to request continued Access to Care on behalf of the members. Customer Care Center representatives may refer new enrollees requesting continued Access to Care directly to the Medical Management Department.

B. Continuing medical services for newly enrolled members or Medi-cal beneficiaries who transition from Fee-for-Service Medi-cal into Medi-cal Managed Care (Anthem) who request continued access, Anthem will provide continued access for up to 12 months to an out of network provider if:

- The provider meets Anthem’s applicable professional standards and has no disqualifying quality-of-care issues. Under these circumstances, a quality-of-care issue means Anthem can document its concerns with the provider’s quality of care
The internal policies and procedures outlined herein are to be used for the Medicaid Business Unit.

C. If a member changes managed care plans (MCP), the continuity of care period may start over one time. If the member changes MCPs a second time (or more), the continuity of care period does not start over meaning that the member does not have the right to a new twelve months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls in an MCP, the continuity of care period does not start over. If a member changes MCPs, this continuity of care policy does not extend to in-network providers that the beneficiary accessed through their previous MCP.

D. When an individual’s FFS provider, or Primary Medical Group (PMG)/Independent Physician Association (IPA) terminates its contract with Anthem or is terminated by Anthem, members are notified of the impending termination and of their right to request continued Access to Care. Development of a transition plan addressing continuity of care is required for those members:

1. In an active course of treatment for an acute medical or behavioral health condition.
2. In an active course of treatment for a serious chronic condition.
3. Who are pregnant, regardless of trimester.
4. With a terminal illness.
5. Who are a newborn child between the ages of birth and 36 months.
6. With a surgery or other procedure that has been authorized by the plan or its delegated provider and is scheduled to occur within 60 days of the contract’s termination or within 60 days of the effective date of coverage for a newly covered enrollee.

E. For hospital termination, Anthem notifies members 60 days in advance of termination only if that hospital is capitated and members are assigned to a specific hospital. For non-capitated hospital terminations, Anthem notifies members if the hospital actually terminates.

F. In the case of continuity of care for a member who has been receiving services from a nonparticipating mental health provider for an acute, serious, or chronic mental health condition, Anthem will allow the member a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to a participating provider. This will include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider.

1. The length of the transition period will be made on a case-by-case basis and will take into account the severity of the member’s condition, and the amount of time reasonably necessary to safely transfer the member to a participating provider. Reasonable consideration will be given to the potential clinical effect of a change of provider will have on the member’s treatment for their condition.

G. Continuing medical services for any LIHP Member who has transitioned into Medi-Cal and thus Anthem may remain with their Primary Care Provider or may request continued access to out-of-network Medi-Cal FFS providers for up to 12 months. For these former LIHP beneficiaries, the 12-month timeframe begins on January 1, 2016 regardless of when the request is made in 2016.
H. If the member’s MER has been denied by the state, then Anthem will utilize the Exemption Transition Data Report from the state on a weekly basis to identify these members. Anthem will start processing these requests for COC within 5 business days of the request and be completed within 30 calendars days of the request. If there is a more immediate need it will be completed in 15 calendar days of the request. If there is risk of harm to the member, the request will be completed within 3 calendar days of the request. Anthem will take steps to insure the member is connected to appropriate care.

I. Continuity of care does not apply to DME (durable medical equipment), transportation, other ancillary services and carved-out services.

II. Case Intake

A. When a member, member advocate, caregiver, or provider contacts Anthem to request continued Access to Care, the Utilization Management or Case Management (UM/CM) Nurse in the Medical Management Department is responsible for the following:
   1. Acknowledging receipt of the request for assistance;
   2. Gathering accurate demographic information from the request for continued Access to Care;
   3. Ensuring member eligibility;
   4. Verifying scheduled date of service or delivery, if necessary;
   5. Determining if there is a pre-existing relationship with the provider;
   6. Re-establishing case priority based on new information or member’s expectation;
   7. Advising the member of the toll free Customer Care number;
   8. Informing the member of the Continued Access to Care process, and answering the member’s questions; and
   9. Establishing a case in the medical management documentation system and documenting all calls and outcomes on requests for continued Access to Care.

B. Once a request for continued Access to Care occurs, Anthem must begin to process the request within five (5) working days after receipt of the request. The continuity of care
The internal policies and procedures outlined herein are to be used for the Medicaid Business Unit. The process begins when Anthem determines there is a pre-existing relationship and has entered into an agreement with the provider. The continuity of care request must be completed within 30 calendar days from the date Anthem received the request, or sooner if the beneficiary’s medical condition requires more immediate attention.

C. Medical Management is also responsible for independently identifying members who may qualify for continued Access to Care at the time of a provider termination, member transfer, or upon enrollment into the health plan.

D. Network Support will provide the Medical Management Department with a list of all members impacted by the termination of a provider.

E. A Case Manager will identify all members with an open case management case and will continue to coordinate the member’s care, facilitating the transfer of records and other information to the new provider as necessary.

F. For Seniors and Persons with Disabilities (SPD) members and Targeted Low Income children, a UM/CM Nurse will contact all physicians involved (Primary Care Provider [PCP] and specialist) to help facilitate the proper transfer of medical records in a timely manner, so as not to interrupt the treatment plan of the member. Upon request, the UM/CM Department will assist the member to ensure the transition to the new physician is successful and there are no questions or concerns.

### III. Assessment and Determination

A. UM/CM licensed associates review, and approve all requests for continued Access to Care. Approval or denial for continued Access to Care is made on the basis of the member’s specific clinical condition, and medical needs. With the exception of maternity, the determination is not solely based on the member’s diagnosis. Medical records or other information are requested when additional information is needed to make a
The internal policies and procedures outlined herein are to be used for the Medicaid Business Unit.

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### Transition Assistance/Continuity of Care

**Effective Date**: 03/29/04  
**Date of Last Review**: 07/24/18  
**Date of Last Revision**: 07/24/18  
**Dept. Approval Date**: 07/24/18

**Department Approval/Signature:**

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B. If the UM/CM Nurse cannot approve the request for clinical reasons, the request is referred to a Peer Clinical Reviewer (PCR) or Medical Director for determination.

C. The UM/CM Nurse may determine that the member is not eligible for continued Access to Care for non-clinical reasons. Non-clinical reasons may include:
   - Treating physician is a contracted provider.
   - Member withdraws the request.
   - Request is for change of PCP only (refer to customer services).
   - Anthem Medicaid coverage not selected.
   - Date of service is prior to the member’s effective date with Anthem Medicaid.
   - Course of treatment has been completed.
   - Services rendered are covered under a global fee.
   - Requested services are not a covered benefit with Anthem Medicaid.

D. The UM/CM nurse shall accept and approve retroactive requests for continuity of care when the definition of continuity of care has been met and meets the following requirements:
   - Have dates of service that occurred after December 29, 2014
   - Have dates of service within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
   - Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested.

### IV. Notification
A. The UM/CM Nurse promptly notifies the provider of Anthem’s determination as to whether or not authorization for continued Access to Care has been granted. Additionally, confirmation of an adverse determination is sent to the member within two (2) business days of the determination.

B. If continued Access to Care will be provided, Anthem notifies the terminating/non-participating provider of the following:
   - Specific services authorized to be provided by the terminating/non-participating provider.
   - Frequency and duration of authorized services.
   - Provider reimbursement rate.
   - Billing instructions for the provider.
   - Toll free telephone number and address for the UM/CM department.
   - Toll free telephone number for Customer Care to verify benefits.

V. Transition Care Plan

A. Only patients approved for continued Access to Care can complete their current treatment plan with the terminating provider. Anthem members who do not meet the eligibility requirements for continuing care with their present provider may seek assistance from Anthem in selecting a participating provider. Anthem will provide assistance in transitioning the patient to a participating provider. Continued Access to 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.

B. When continued Access to Care is approved, the UM/CM Nurse develops and documents a transition plan for the member. Plan development includes contact with the member and the treating provider, as needed, and the participating provider to whom the member’s care will be transferred, as appropriate.

C. The transition plan includes at least:
The non-participating provider’s treatment plan for the member’s active course of treatment, for which continued Access to Care was requested.

- The specific treatment goal to be reached prior to transfer to the Anthem contracting provider and the estimated date the transfer can be safely accomplished.

D. The continued Access to Care plan and the member’s progress are documented at intervals appropriate to the specific case. The transition plan includes and documents referral to appropriate Anthem resources.

E. The UM/CM Nurse documents transition of care process provided to member in the case notes. The MCP must notify the beneficiary 30 calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the beneficiary and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

F. For the MRMIP members, appropriate referrals to Comprehensive Care Management include members who:

- Have received a transplant or transplant rejection within the prior twelve (12) months.
- Are on a transplant waiting list or are in an assessment program.
- Meet Comprehensive Care Management referral guidelines.

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

H. If a Targeted Low-Income member has transitioned into Medi-Cal and is not able to remain with their Primary Care Provider, Anthem Medicaid will develop a care plan on how the Member will continue to receive services which they had been receiving at the time of the transition. Anthem Medicaid will report this care plan to the DHCS to show
VI. Case Completion and Closure

A. A continuity of care request is considered completed when:
   - the beneficiary is informed of his or her right of continued access, or
   - if Anthem and the out-of-network FFS provider are unable to agree to a rate,
   - Anthem has documented quality-of-care issues, or
   - Anthem makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

B. The 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.
   - Continued Access to Care request is denied and the member and provider are notified.
   - A request for continued Access to Care has been received with missing member information and or clinical information. Note: If this occurs, two (2) attempts will be made to reach the member and if no response, a denial letter for lack of clinical information will be generated for outpatient services.

VII. Non-Applicability

A. Anthem 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.

B. New enrollee to Anthem with other primary coverage such as Medicare.
The internal policies and procedures outlined herein are to be used for the Medicaid Business Unit.

VIII. Reimbursement to Providers

A. Following identification of a pre-existing relationship, the Anthem UM/CM Nurse will determine if the provider is an in-network provider. If the provider is not an in-network provider, the UM/CM Nurse will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the beneficiary. The nurse will also inquire whether or not the provider is willing to accept the State of California’s current Medicaid or Anthem’s rates (whichever is higher). If the provider is unwilling, he/she is referred to Anthem’s Provider Education & Contracting (PE&C) department for further negotiation of rates. If the provider is willing to accept Anthem’s rates, and no known quality of care issues are present, then Anthem shall allow continued access to that provider.

B. If Anthem and the out-of-network FFS provider are unable to reach an agreement because they cannot agree to a rate, the requested provider has refused Anthem’s proposed rate, or Anthem has documented quality-of-care issues with the provider, UM/CM will work with the member to select another participating provider. If the member does not make a choice, the member will be assigned to an in-network provider. Members maintain the right to pursue an appeal through the Medi-Cal processes.

C. If a provider meets all of the necessary requirements including agreeing to a letter of agreement or contract with Anthem, Anthem will ensure the member has access to that provider for the length of the continuity of care period unless the provider is only willing to work with Anthem for a shorter timeframe. In this case, Anthem will allow the member to have access to that provider for the shorter period of time.
D. In addition to the reimbursement rate, the terminating/non-participating provider must agree to the following:

- Provide necessary medical information related to the care.
- Adhere to Anthem’s quality management requirements.
- Continue to accept reimbursement of the Anthem-negotiated rate as payment in full.
- Adhere to Anthem’s policies and procedures, including but not limited to, those regarding referrals, pre-authorization and treatment plan approval from Anthem.

E. Provider questions about reimbursement rates outside the continued Access to Care program are referred to Network Support.

REFERENCES:
- Anthem Medicaid Policy #CA_PNXX_303 “Provider Termination”
- California Business and Professions Code Section 805(a) (6)
- California DHCS Central Valley/Bay Area, Sacramento, Tulare County Medi-Cal Contracts, Exhibit A, Attachment 9 and Attachment 22
- California Health & Safety Code 1373.95& 1373.96
- Department of Health Care Services, All Plan Letter #18-008 http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
- MRMIP PPO, Evidence of Coverage, Effective January, 2017
- National Committee for Quality Assurance (NCQA)
- Provider Operations Manual, Effective July 2017

RESPONSIBLE DEPARTMENTS:

Primary Department:
Medical Management: Utilization Management and Case Management
The internal policies and procedures outlined herein are to be used for the Medicaid Business Unit

CA_CAXX_079
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**SUBJECT (Document Title)**
Transition Assistance/Continuity of Care

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- Added timeframes for when requests need to be completed
- Added retrospective request section
- Changed all plan letter #
- Added MER definition and process

**01/07/14**
- Edited company name throughout document for consistency purposes as directed by Compliance.
- Added definition for Low Income Health Plan member
- Updated Qualifying Conditions to reflect current language and timeframes dictated by CA Health and Safety (H&S) Code 1373.96
- Removed disabling and degenerative conditions from list of qualifying conditions as this is not listed in the required conditions for continuity of care per CA H&S Code 1373.96.
- Added statement concerning continuity of care for a member who has been receiving services from a nonparticipating mental health provider.
- Added verbiage for continuity of care for LIHP members.
- Updated to include timeframes for processing requests for continuity of care.
- Updated process within section of Reimbursement to Providers.
- Updated circumstances for when the member may be granted access to a non-participating provider.
- Added verbiage for when the continuity of care request is considered complete.
- Grammar, formatting, and changes made to the organization of the content for clarify and ease of understanding
- References updated

**07/18/13**
- Removed statement from Section VIII.C. that the provider will be notified with a fax confirmation form. This is no longer done.
- Updated Section X.A. bullet 4. Deferral letters are no longer sent, however denial letters are sent in these situations.
The internal policies and procedures outlined herein are to be used for the Medicaid Business Unit

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**Transition Assistance/Continuity of Care**

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**Revision History**

- 03/08/13
  - Added requirements for Targeted Low Income children’s transition into Medi-cal.
  - Reformatted
  - Updated references

- 10/12/12
  - Changed reference from Anthem Blue Cross State Sponsored Business to Anthem Medicaid.
  - Updated SECTION reference from Care Management to Case Management
  - Updated policy title to remove Transition Assistance as it was used twice
  - Replaced reference of “aged, blind, and disabled” to “Seniors and Persons with Disabilities (SPD)”
  - Added new SPD contract language with regards to continuity of care for newly enrolled SPD members
  - Changed reference from Care Management to Medical Management
  - Corrected formatting
  - Updated references
  - Added revision history to policy