# Procedures for Continuity of Care

## Purpose

This policy defines the process to provide Continuity of Care for members to comply with Rule 09-03, the Consolidated Appropriations Act of 2021 and NCQA requirements.

## Scope

| | | |
|---|---|---|
| Blue Cross VT | X Yes | ___No |
| Qualified Health Plans (QHP) | X Yes | ___No |
| TVHP | X Yes | ___No |
| Federal Employee Program (FEP) | X Yes | ___No |
| New England Health Plan (NEHP) | X* Yes | ___No |

**In the event, Blue Cross VT is the Home Plan.*

## Regulatory/Accreditation Links (if applicable)

NCQA 2024 HPA Standards: NET 4B
Vermont Rule 09-03 Standards: 5.1 G, 5.1H, 5.3L, 5.3M
Section 113, Consolidated Appropriations Act of 2021, Public Health Services Act Sec. 2799-A-3

**Effective Date:** 8/98
**Revision Date**: 8/2024
**Next Review Date:**
8/2025
**Last Approved:** 9/8/23, Accreditation Team
**Divisions:** Consumer Service & Planning; Provider Services, Utilization Management
**Policy Links:** Assignment of Primary Care Provider (PCP) and Provider Specialist Terminations; Specialist Role in Managed Care; Continuity of Care Form

## Revisions

| Date of Change | Effective Date | Overview of Change |
|---|---|---|
| 8/2024 | | Corrected department responsible for determining if a member has a Qualifying Condition from integrated health to utilization management. |
| 8/2024 | | Clarified the following process functions:<br>• Possible referrals to care management programs<br>• Including the COC protection period dates<br>• When a member can be balanced billed<br>• When appeal rights are applicable<br>• How to handle previously granted prior approvals |

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## Policy

**This Policy Applies To:**

- Existing Members whose provider is not in the Blue Cross and Blue Shield of Vermont (Blue Cross) network due to the expiration or non-renewal of a contract with Blue Cross and who are undergoing treatment for a Qualifying Condition;
- New Members whose provider is not in-network because of a plan change to Blue Cross and who are undergoing treatment for a Qualifying Condition.

For members who qualify based on the below criteria, benefits are provided according to the terms, limitations and conditions of the member's certificate of coverage or summary plan description.

Members are entitled to Continuity of Care protection when the provider treating their Qualifying Condition is no longer available in network.

The purpose of Continuity of Care protections is to ensure the orderly transition from an out of network provider treating a Qualifying Condition to an in-network provider. When Continuity of Care protections are granted, members must be notified of their obligation to find an in-network doctor and that failing to do so in the time periods outlined below may result in the member having to pay the full cost of their care.

## Definitions

"Balance bill" means when a provider bills for the difference between the provider's charge and Blue Cross's allowed amount. For example, if the provider's charge is $100, and the Blue Cross of Vermont allowed amount is $70, the provider may bill the member the remaining $30 if balance billing is permitted.

"Continuity of Care" refers to providing coverage to a member as if an out-of-network provider is in-network during the Continuity of Care protection period. It is the plan's position that the provider must accept the in-network rate of payment for the services provided during the Continuity of Care protection period. In the event the provider refuses to accept the in-network rate, the member can be balance billed.

"Disabling" means the disease or condition alters the individual's ability to

- function in his or her occupation;
- control his or her activities of daily living; and/or
- function within society.

"Life threatening" means the disease or condition is likely to be the proximate cause of death.

"Degenerative" means the disease or condition is recognized in the medical literature for progressive deterioration of any body part, organ or system.

"Qualifying Condition" means a condition for which person:

- is undergoing a course of treatment for a serious or complex condition (defined below) from that provider;
- is undergoing a course of institutional or inpatient care from that provider;
- is scheduled to undergo nonelective surgery (this includes post-operative care related to the surgery);
- is receiving care for a pregnancy from the provider; or
- is receiving care or treatment for a terminal illness from that provider.

"Serious or Complex Condition" means a condition that (a) in the case of an acute illness requires specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in relation to a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time.

## Procedures

1. At the time of enrollment, new members may request to receive a paper Continuity of Care form or they can complete the form and submit it electronically through the Member Resource Center (MRC). Requests may also be generated from client solutions, customer service or other internal departments.

2. When an existing member is notified a provider who is treating them is leaving the Blue Cross network, the existing member may request to receive a paper Continuity of Care form or they can complete the form and submit it electronically through the MRC. Requests may be generated from client solutions, customer service or other internal departments.

3. Depending on the circumstances, utilization management may refer the matter to integrated health, and case management will assist the member in locating and transitioning to contracted providers. Case management should seek to help when:
   - The need for treatment will exceed the Continuity of Care protection period

- The member's health condition indicates the need for case management services.

4. Utilization management's decision that the member does not meet criteria for continued care is considered an adverse determination. The member and/or provider(s) shall be afforded the same appeal rights that are available with any other adverse determination.

**Continuity of Care Protections for Existing Members:**

1. An existing member is entitled to Continuity of Care protections when a provider leaves the Blue Cross network. Continuity of Care protections do not apply when a provider is terminated from the network for cause when the "cause" is determined to be violating Blue Cross of Vermont's quality standards or for fraud. This is also true for providers terminated by other Blue plans for cause. Determination of whether a provider was terminated for cause shall be the responsibility of the Contracting Counsel.

2. When a provider leaves the network, customer service sends all members who are currently seeing the provider a notice that the provider is leaving the network. This notice will notify members of the need to find a new provider and provide members with information about how to seek Continuity of Care protection by submitting a Continuity of Care form. If the member has a Qualifying Condition and is being treated by a provider who has left the Blue Cross network, but the member would like to continue to see that provider, the member shall submit the Continuity of Care form for review by utilization management.

3. Upon receipt of the completed Continuity of Care form, forms are forwarded to mail and document management. Then utilization management reviews the Continuity of Care form to determine if the member has a Qualifying Condition. Utilization management may ask for additional clinical information needed to determine if the member is entitled to Continuity of Care protections because they have a Qualifying Condition.

4. If utilization management determines the member has a Qualifying Condition, utilization management notifies the member they are entitled to Continuity of Care protection. The plan will continue to pay the provider the in-network rate for the duration of the Continuity of Care period (see below). Blue Cross will attempt to get the terminating provider to continue to accept the in-network allowed amount during the Continuity of Care period, but the member may be balance billed if the provider will not agree. The member should be notified if the provider will not agree to accept the in-network rate for the Continuity of Care protection period. Utilization management also reviews the form to determine member appropriateness for referral to chronic care, maternity wellness or case management programs.

    - The notice granting Continuity of Care should note how long the Continuity of Care protection period lasts (see below). The notice shall inform the member they need to transition to a new in-network provider if care needs exceed the Continuity of Care protection period.

5. Utilization management shall refer the matter to case management to assist the member in locating contracted providers, if applicable. Once the Continuity of Care period expires, the Out of Network policy applies. If the member wishes to continue with the non-contracting

provider, the member may have no coverage, may have higher cost share and may be subject to balance billing, depending on the terms of their plan.

6. If utilization management determines the member does not have a Qualifying Condition, that is considered an adverse determination. The members and/or provider(s) shall be afforded the same appeal rights that are available with any other adverse determination.

**Continuity of Care Protections for Members that Are New to the Plan:**

1. Members who are new to the plan and who were seeing a provider for a Qualifying Condition who was in network under their previous coverage with another plan, are entitled to Continuity of Care protections. Prior to enrollment or within 90 days of enrollment, a new member may request a Continuity of Care Form. Requests may be generated from client solutions, customer service or other internal department(s).

2. Upon receipt of the completed Continuity of Care form, forms are forwarded to mail and document management. Then utilization management reviews the Continuity of Care form to determine if the member has a Qualifying Condition.

3. Upon receipt of the completed Continuity of Care form, utilization management will determine if the member has a Qualifying Condition. Utilization may request additional clinical information in its analysis. Upon confirmation that the member has a Qualifying Condition, utilization management will send a letter notifying the member of the decision. Utilization management also reviews the form to determine member appropriateness for referral to chronic care, maternity wellness or case management programs.

    - The notice granting Continuity of Care should note how long the Continuity of Care protection period lasts (see below). The notice shall provide that the member should not be balance billed by the provider. The notice shall inform the member they need to transition to an in-network provider if care needs exceed the Continuity of Care protection period.

4. During the Continuity of Care period, the existing treating provider will be treated as if the provider were in-network with Blue Cross. Benefits will apply as if the provider is in-network and the provider will be paid the contracted rate for services. However, if the provider refuses to accept either the Blue Cross rate or the rate from the member's prior insurer (although required by the CAA), the member may be balance billed. In the event the provider refuses to accept the in-network rate, the provider will be given an opportunity to show that the provider was paid more by the previous payer. Upon receipt of such proof, Blue Cross will match the previous payer's rate.

5. If utilization management determines the member does not have a Qualifying Condition, that is considered an adverse determination. The members and/or provider(s) shall be afforded the same appeal rights that are available with any other adverse determination.

6. **Previously Granted Prior Approval:** If a member has a valid, in-force, prior approval from their prior health plan, and the member is stable as determined by their health care provider,

Blue Cross shall honor the previous plan's prior approval for the first 90 days after the member has enrolled with Blue Cross. The 90-day period begins at enrollment, regardless of when the member applies for protection. The prior approval applies to the service, treatment or medication, it does not mean the member is entitled to go out-of-network for the service unless another Continuity of Care protection applies. This is true even if the member received a prior approval from their previous health plan to receive the services out-of-network.

**Continuity of Care Protection Period**

1. Subject to the caveats below, the Continuity of Care protection period for new members generally lasts for 90 days after enrollment, assuming the member was notified at enrollment of the right to seek Continuity of Care protections. The Qualifying Condition must exist before enrollment.

2. For existing members, the Continuity of Care protection lasts for 90 days after the treating provider termination if the provider agrees to accept the in-network rate for the services. The Qualifying Condition must occur prior to the termination.

3. For existing members, if the terminating provider refuses to accept the in-network rate, the Continuity of Care protection period lasts for 60 days after the provider termination, but must also extend for 90 days after the notice of termination was provided to the member. In the event the provider does not accept the in-network rate, utilization management must notify the member that the provider may balance bill the member for the services. The Qualifying Condition must occur prior to the provider termination. See Questions and Answers below for examples.

4. If a member's Qualifying Condition course of treatment concludes before the end of the Continuity of Care protection period, the protection period ends. For example, if a member is discharged from a non-network inpatient facility, the Continuity of Care protection period ends.

5. **In the event of pregnancy**, the Continuity of Care protection period lasts through pregnancy until completion of initial postpartum care. Note, that if the member enrolled with Blue Cross prior to the second trimester and the out of network provider refuses or fails to agree to the in-network rate consult with legal about the Continuity of Care protection period.[1] If the provider still refuses to accept the in-network rate, utilization management must notify the member that they can be balance billed.

6. For those members who are terminally ill, Blue Cross may, at its discretion, extend the Continuity of Care protections beyond the ninety (90) days. Extensions must be authorized by a Medical Director.

[1] Note that Rule 09-03 provides that a woman who enrolls in the second or third trimester is entitled to out of network care through post partum care. DFR Rule H-2009-03, Section 5.1 (G)(2). The CAA only requires 90 days of coverage. CAA, Section 113, adding PHSA Section 2899A-3.

**Internal Procedures Relating to Providers**

1. Voluntary resignation notices received from providers are forwarded to Provider Contracting at ProviderContracting@bcbsvt.com . Provider contracting shall request customer service to generate a report that identifies all members currently under the provider's care. Customer service sends notification letters to members advising their provider is leaving, the length of their Continuity of Care protection period if they have a Qualifying Condition, and additional steps to take to ensure a smooth transition, including advising them how to select another PCP or specialist.

2. When Continuity of Care protections apply, it is the plan's position that pursuant to both the CAA and Rule 09-03 the provider must accept Blue Cross's in-network rate (or the rate of the previous insurer, if there is one) during the Continuity of Care protection period. However, if the provider refuses to do so, the member can be balance billed and must be notified. If a provider refuses to accept the in-network rate, no single case agreement is required. A single case agreement should only be entered into to reflect the provider's willingness to accept the in-network rate. Provider contracting sends the agreement document to the provider outlining the member's request to maintain their care and the requirements to provide continued care. The agreement is signed by the provider and Blue Cross. The requirements are:
    a. Abide by the negotiated payment rates;
    b. Abide by the health benefit Plan's quality of care standards
    c. Abide by the health benefit Plan's quality of care protocols; and
    d. Provide necessary clinical information to the Plan.

3. The provider's decision not to enter into a single case agreement with in-network rates and voluntarily abide by the plan's requirements for continued care is not an adverse decision – therefore, appeal rights are not applicable. The member should be notified that the provider may balance bill the member.

## Annual Review

The Accreditation Team will review this policy and procedure annually to ensure it is consistent with current business practices and reflects the latest regulatory and accreditation standards, as applicable.

# APPENDIX (for internal use only)

## Questions and Answers

**Question 1: A provider leaves the Blue Cross network. Blue Cross notifies the member on October 23, stating that the provider would no longer be in network on February 1. The member is receiving care for a Qualifying Condition. Blue Cross received the member's Continuity of Care Form on January 21. When does the Continuity of Care transition period begin?**

Answer 1: The Continuity of Care protection period begins when the termination is effective, February 1. If the provider agrees to accept the in-network rate, the Continuity of Care protection period runs for 90 days. If the provider does not accept the in-network rate, the Continuity of Care protection period runs for 60 days and the member can be balance billed. The member should be notified if the provider will not accept the in-network rate. Treatment for the Qualifying Condition must have begun prior to February 1.

**Question 2: A provider leaves the Blue Cross network on February 1. Blue Cross did not notify existing members. The member is seeing the provider for a Qualifying Condition. The member completes their Continuity of Care Form on April 21. When does the Continuity of Care transition period begin?**

Answer 2: For purposes of 09-03, Continuity of Care begins to run on February 1 and will last for 60 days. Treatment for a Qualifying Condition must have occurred prior to February 1. For purposes of CAA, because Blue Cross did not notify the member of the upcoming termination, the Continuity of Care protection period begins to run on April 21, the date that the member made the request. The Continuity of Care protection period lasts for 90 days. Treatment for the Qualifying Condition must have occurred prior to April 21. If the qualifying condition occurred prior to February 1, and therefore the member has a right to both 09-03 and CAA protections, we will also cover the gap in between those two time periods to avoid member confusion. However, in all scenarios, the Continuity of Care protection only applies to treatment for the Qualifying Condition. Additionally, provider contracting should be notified to ensure required notices of the provider termination are mailed to impacted members.

Note, that in the event of pregnancy, the coverage protection lasts until the end of the pregnancy. Further, in the event of a terminal illness, the plan may use its discretion to extend the continuity of care protection period.

Note, if notice of a provider termination does not go out timely and there is an exceptionally long time between notice periods, please contact the legal department to discuss maintaining protection during the gap.

**Question 3: A member is new to Blue Cross with a plan starting on January 1. The member does not complete a Continuity of Care form until May 1. When does the member's Continuity of Care protection period begin?**

Answer 3: The member's Continuity of Care protection began on January 1 in this example. Members are notified of their Continuity of Care rights as part of the enrollment process and have the right to seek Continuity of Care protection within 90 days. Unless the member's Qualifying Condition is pregnancy, the member's Continuity of Care protection period ended 90 days after enrollment – March 30. Note that the patient must have been undergoing treatment for a Qualifying Condition before enrollment with Blue Cross. Thus, even if a member seeks Continuity of Care protection within the 90 day period, the actual treatment must have been ongoing prior to January 1 in this example. If the

member's Qualifying Condition is pregnancy, their Continuity of Care protection will continue through the end of initial post-partum care. Again, the member must have been seeing the provider for their pregnancy prior to January 1 in this example.

# 2024_Procedures for Continuity of Care Final

Final Audit Report 2024-10-01

| | |
|---|---|
| Created: | 2024-10-01 |
| By: | Jude Daye (dayej@bcbsvt.com) |
| Status: | Signed |
| Transaction ID: | CBJCHBCAABAAfcPOZTi4wryoddoOYEwTrswp-AopmDVN |

## "2024_Procedures for Continuity of Care Final" History

Document created by Jude Daye (dayej@bcbsvt.com)
2024-10-01 - 12:45:53 PM GMT

Document signing automatically delegated to Diane Raymond (raymondd@bcbsvt.com) by Tom Weigel, MD (weigelt@bcbsvt.com)
2024-10-01 - 12:45:57 PM GMT

Document emailed to Catherine Hamilton (hamiltonc@bcbsvt.com) for signature
2024-10-01 - 12:45:58 PM GMT

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2024-10-01 - 12:45:58 PM GMT

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Signature Date: 2024-10-01 - 12:56:25 PM GMT - Time Source: server

Email viewed by Janalee Willett (willettj@bcbsvt.com)
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2024-10-01 - 1:11:33 PM GMT

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