

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.

Policy

Procedures for Continuity of Care: New or Existing Members whose Provider has expired or been terminated; Members whose Provider is no longer in-network because of a plan change to Blue Cross VT/TVHP; Women in their 2nd or 3rd Trimester of Pregnancy; New Members with Life-threatening, Disabling or Degenerative Conditions; and Continued Care After Practitioner Resignation.

Effective Date: 8/98

Revision Date: 7/7/09, 7/1/10, 04/11; 11/13; 3/15; 1/16; 1/17; 1/18; 1/19; 12/23/21

Next Review Date: 2/20

Last Approved by SOC: 04/07/11; NA

Last Approved by MEC: 12/19/13; 3/10/15; 2/24/16; 2/13/17; 2/15/18; 4/3/19, 1/12/22

Approved by: Member Experience Committee (MEC)

Division: Consumer Services; Provider Relations; Integrated Health

Applies To:

BCBSVT	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Qualified Health Plans (QHP)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
TVHP	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Federal Employee Program (FEP)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
New England Health Plan (NEHP)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Reference:

Assignment of Primary Care Provider (PCP) and Provider Specialist Terminations
Specialist Role in Managed Care
Continuity of Care Form

Definitions

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

“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.

“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 person: (1) who is receiving care for a serious or complex condition (defined below); (2) was in the course of institutional or inpatient care; (3) had a scheduled nonelective surgery (this includes post-operative care related to the surgery); (4) was receiving care or treatment for a pregnancy; or (5) was receiving care or treatment for a terminal illness.

“Serious or Complex Condition” means a condition that (a) requires specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) is 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.

Policy Guidelines

The guidelines for continuity of care for members actively enrolled are as follows:

1. New members with a life-threatening, disabling, or degenerative condition or women in their second or third trimester of pregnancy, and
2. Existing members with a life-threatening, disabling, or degenerative condition or women in their second or third trimester of pregnancy when:
 - a. Their providers voluntarily resign from the network but remain in the service area, or are terminated by the Plan without cause or for an issue not related to quality of care; or
 - b. Their providers voluntarily resign from the network and move out of the service area, expire, or are not terminated due to a quality of care issue.
3. Members where, because of an employer-initiated plan change to Blue Cross VT, their treating provider for their qualifying condition is no longer in-network. These members may be elect to continue their benefits for ninety (90) days for a qualifying condition with the existing provider as if the provider were in-network with Blue Cross . These continuity of care protections outlined in this subsection (3) begin to run on the date the member elects these continuity of care rights. Upon the expiration of the ninety (90) day period, the member will no longer be entitled to the rights and protections outlined in this subsection (3). However, in cases where a member is receiving care for a terminal illness, BCBSVT may, at its discretion, extend the continuity of care benefits beyond the 90 period to ensure little or no interruption to the member managing a terminal illness.

Additionally, the Plan may consider requests on a case-by-case basis from new or existing members currently receiving a course of treatment with a particular, non-contracted provider when required by state or federal law.

Note: For continuity of care benefits provided under Rule 09-03, benefits are provided according to the terms, limitations and conditions of the subscriber’s certificate of coverage or summary plan description. For continuity of care benefits provided under the CAA, benefits will be provided as though the existing provider were in-network with Blue Cross.

Blue Cross and Blue Shield of Vermont and The Vermont Health Plan have established procedures for:

1. A female member new to the Plan in her second or third trimester of pregnancy to continue to receive care from her previous non-participating provider until the completion of postpartum care (generally up to six weeks).
2. A new member with a life threatening, degenerative, or disabling condition to continue to receive care from his/her previous non-participating provider for a 60-day transitional period after enrollment.
3. An existing female member in her second or third trimester of pregnancy under the care of a participating provider that is leaving the Plan and agrees to certain provisions, to continue to receive care from her current provider after network termination until the completion of postpartum care (generally up to six weeks).

4. An existing member with a life threatening, degenerative, or disabling condition under the care of a participating provider that is leaving the Plan and agrees to certain provisions, to continue to receive care from his/her current provider for a 90-day transitional period after network termination.
5. Notification of existing members affected by termination of a current provider that has voluntarily resigned from the network and moved out of the service area, expired, or is terminated due to a quality of care issue.
6. New member to BCBSVT and have previously received approval from a prior insurance carrier for an upcoming scheduled service.

Note: Information regarding continuation of care is provided to:

- New members in the Plan document, and
- Members affected by termination of their existing provider through letter notification.

Procedures

Members Who are New to the Plan and Subject to Rule 09-03:

1. At the time of enrollment, new members may receive a paper Continuity of Care Form to fill out or they can complete the form and submit electronically through the Member Resource Center (MRC). Requests may also be generated from Client Solutions, customer service or other internal department(s).
2. Upon receipt of the completed request for continued care, forms are forwarded to mail and document management.
3. Based on the completed request for continued care, and upon active membership, integrated health (IH) will review the request according to utilization review guidelines for the specific service or procedure. IH will send a letter to notify the member of the decision, or to request the relevant clinical information. IH also reviews the forms to determine member appropriateness for referral to chronic care, maternity wellness or case management programs, and if applicable, the member will receive an outreach call to further assess for program participation.
4. The appropriate clinical review staff review any necessary, additional clinical information received. Based upon the review of information, the clinical reviewer determines whether the member meets the criteria for continued care.
5. If the clinical reviewer determines the member meets our criteria, the member is notified they can be billed for the non-allowed amount when seeing a non-contracting provider. UM refers to CM, and CM assists the member in locating contracted providers, if applicable. If the member wishes to continue with the non-contracting provider, the non-allowed amount will be a significant financial hardship and there are not contracting providers that provide the services, the Plan will try to enter into a single case agreement with the provider. If it is an out-of-state provider, the Plan will contact the Host plan to ask if we can negotiate with the provider.
6. If we negotiate a single case agreement, provider relations sends the agreement document to the provider outlining the member's request to maintain their care with that provider and the requirements to provide continued care. The agreement is signed by the provider and BCBSVT. The requirements are:
 - a. Abide by the health benefit Plan's 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.

7. If the provider does not wish to enter into a single case agreement or the Host plan denies our request to negotiate with the provider, we have no control over the quality of care. We will still authorize/allow for the provision of the requested care and provide assistance and support to the member (e.g. with sending us clinical information we request). The provider's decision not to enter into a single case agreement and voluntarily abide by the Plan's requirements for continued care is not an adverse decision, therefore, appeal rights are not applicable.
8. The clinical reviewer's decision that the member does not meet criteria for continued care is considered an adverse determination; members and/or provider(s) shall be afforded the same appeal rights that are available with any other adverse determination.

Existing Members:

1. Voluntary resignation notices from providers are forwarded to the provider relations department. Provider relations works with the reimbursement and analytics department 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 customer service department will send the standard PCP (Primary Care Provider) and Specialist notification letters to all of the members in the provider's panel advising them how to select another PCP or specialist.
2. If the member is in active treatment with a provider who voluntarily resigned but the member would like to continue to see that provider, the appropriate clinical review staff reviews any necessary, additional clinical information received. Based upon review of information, the clinical reviewer determines whether the member meets the criteria for continued care.
3. If the clinical reviewer determines the member meets our criteria, the member is notified they can be billed for the non-allowed amount when they see a non-contracted provider. The clinical reviewer assists the member in locating contracted providers, if applicable. If the member wishes to continue with the non-contracting provider, the non-allowed amount will be a significant financial hardship and there are not contracting providers that provide the services, the Plan will try to enter into a single case agreement with the provider. If it is an out-of-state provider, the Plan will contact the Host plan to ask if we can negotiate with the provider.
4. If we negotiate a single case agreement, the clinical reviewer 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 BCBSVT. The requirements are:
 - a. Abide by the health benefit Plan's 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.
5. If the provider does not wish to enter into a single case agreement or the Host plan denies our request to negotiate with the provider, we have no control over the quality of care. We will still authorize/allow for the provision of the requested care and provide assistance and support to the member (e.g. sending us clinical information we request). The provider's decision not to enter into a single case agreement and voluntarily abide by the Plan's requirements for continued care is not an adverse decision – therefore, appeal rights are not applicable.
6. The clinical reviewer's decision that the member does not meet criteria for continued care is considered an adverse determination; members and/or provider(s) shall be afforded the same appeal rights that are available with any other adverse determination.

Members Who are New to the Plan and Subject to the CAA:

1. Members may request to receive a paper Continuity of Care Form to fill out. Requests may also be generated from Client Solutions, customer service or other internal department(s).
2. Upon receipt of the completed request for continued care, forms are forwarded to mail and document management.
3. Based on the completed request for continued care, and upon confirmation that the member has a qualifying condition, integrated health (IH) will review the request according to utilization review guidelines for the specific service or procedure. IH will send a letter to notify the member of the decision, or to request the relevant clinical information. IH also reviews the forms to determine member appropriateness for referral to chronic care, maternity wellness or case management programs, and if applicable, the member will receive an outreach call to further assess for program participation. The existing provider will be treated as if the provider were in-network with Blue Cross.
4. The appropriate clinical review staff review any necessary, additional clinical information received. Based upon the review of information, the clinical reviewer determines whether the member meets the criteria for continued care as outlined above.
5. If the clinical reviewer determines the member meets our criteria, the member will be notified that they have qualified for continuity of care and they can continue their treatment for 90 days and they cannot be balance billed by the provider. The notice also informs them of the need to transition to a new in-network provider. For those members who are terminally ill, Blue Cross may, at its discretion, extend the continuity of care protections beyond the ninety (90) days. The clinical reviewer assists the member in locating contracted providers, if applicable. The member will be entitled to these services for ninety (90) days upon receipt of the letter mentioned in subsection (1) above.
6. The clinical reviewer's decision that the member does not meet criteria for continued care is considered an adverse determination; members and/or provider(s) shall be afforded the same appeal rights that are available with any other adverse determination.

Annual Review

MEC 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.