Policy & Procedure				
Subject:	Continuity of Care			
Policy Number:	UM.706L		**Page(s):**	1 of 6
Supersedes:			**Attachment(s):**	None
Date Reviewed:	02/19/2019			
Current Effective Date:	02/19/2019			
Next Review Date:	02/19/2020	**Review Cycle:**		Annually
Contract Reference(s):	LDH 2015-2018 Sections 6, 6.30,6.32, 6.34, 6.35, 7, 11			

POLICY

ACLA provides continuing coverage of care for Members who are engaged in an ongoing course of treatment with a non-participating Practitioner/Provider and for enrollees determined to need a course of treatment or regular monitoring, to promote continuity of care. In accordance with 42 CFR §438.208(c)(4), ACLA allows enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs in the following situations:

1. Newly Enrolled Pregnant Women

- Who are receiving medically necessary covered services in addition to, or other than, prenatal services (see below for newly enrolled Members receiving only prenatal services) the day before becoming an ACLA Member, ACLA will be responsible for the costs of continuation of such medically necessary services, without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. ACLA will provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. ACLA may require prior authorization for continuation of the services beyond thirty (30) calendar days; however, ACLA will not deny authorization solely on the basis that the Provider is not a contracted provider.

- Who are in the first trimester of pregnancy and are receiving medically necessary covered prenatal care services the day before becoming an ACLA Member. The member can continue to receive such medically necessary prenatal care services, including prenatal care, delivery, and postpartum care, without prior authorization and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider until such time as ACLA can reasonably transfer the Member to a participating ACLA Practitioner/Provider without impeding service delivery that might be harmful to the Member's health.

- Who are in the second or third trimester of pregnancy and are receiving medically necessary covered prenatal care services the day before becoming an ACLA Member can

continue to receive services from their prenatal care Practitioner/Provider (whether a participating or non-participating ACLA Practitioner/Provider) for sixty (60) days postpartum, provided the member is still eligible for Medicaid, or referral to a safety net provider if the member's eligibility terminates before the end of the postpartum period.

2. Newly Enrolled Members

- Who are receiving medically necessary covered services the day before becoming an ACLA Member, can continue to receive such medically necessary services for the first thirty (30) calendar days of enrollment, without the need for medical necessity review and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. After thirty (30) calendar days, prior authorization requirements apply for those services identified as requiring prior authorization. ACLA will continue to provide coverage for services determined to be medically necessary for an additional sixty (60) calendar days or until the Member may be reasonably transferred without disruption, whichever is less. ACLA will not deny authorization solely on the basis that the Practitioner/Provider is not a participating ACLA Practitioner/Provider.

- Who are receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies the day before becoming an ACLA member, whether such services were provided by another MCO or Medicaid fee-for-service, can continue to receive these services, without prior authorization and without regard to whether such services are being provided by a participating or non-participating ACLA Practitioner/Provider. ACLA will continue to provide coverage for services for up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. ACLA will honor any prior authorization for durable medical equipment, prosthetics, orthotics, and certain supplies issued while the member was enrolled in another MCO or Medicaid fee-for-service for a period of ninety (90) calendar days after member's enrollment into ACLA.

- Who have special health care needs and are Medicaid or CHIP eligible and are receiving medically necessary covered services, the day before ACLA enrollment, ACLA shall provide continuation/coordination of services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. ACLA may require prior authorization for continuation of the services beyond thirty (30) calendar days; however ACLA is prohibited from denying authorizations solely on the basis that the provider is a non-contracted provider.

- Who are to be transferred between MCOs but are hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving MCO. However, the relinquishing MCO is responsible for the member's hospitalization until the member is discharged. The receiving MCO is responsible for all other care.

- The Transition report form LDH is received and reviewed monthly to gather and provide appropriate medical records and case management files of the transitioning member to the accepting MCO. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing contractor.

3. Current Members receiving care from a Practitioner/Provider

- May continue an ongoing course of treatment (defined as treatment for a chronic or acute medical condition; behavioral health condition; or life-threatening illness) with a Practitioner/Provider whose contract is terminated with ACLA (either by ACLA or by the Practitioner) for up to ninety (90) calendar days from the effective date of the termination. Coverage for the continuation of an ongoing course of treatment will not be provided in the following circumstances:
- The Practitioner/Provider contract was terminated by ACLA as the result of a professional review action (quality of care issue)
- The Practitioner/Provider is unwilling to continue to treat the member or accept ACLA's payment or other terms

4. Current Members who are in their second or third trimester of pregnancy or who are identified as having a high-risk pregnancy
5. On the date that the Member is notified by ACLA of the termination or pending termination, a member may continue an ongoing course of treatment with a non-participating Obstetrician (OB) or Midwife through the completion of post-partum care related to the delivery. Coverage for the continuation of an ongoing course of treatment will not be provided in the following circumstances:

- The Practitioner/Provider contract was terminated by ACLA as the result of a professional review action (quality of care issue)

- The Practitioner/Provider is unwilling to continue to treat the member or accept ACLA's payment or other terms

6. Indian members who are enrolled and are eligible to receive services from an IHCP primary care provider participating as a network provider, and has the right to the following:

- That IHCP as his or her PCP, as long as that provider has capacity to provide the services.
- To obtain services covered under the contract from out-of-network providers where timely access to covered services cannot be ensured by ACLA.
- An out-of-network IHCP is allowed to refer an Indian member to a network provider.

ACLA Members receiving ongoing treatment, as outlined above, may not be billed for the costs of medically necessary core benefits and services.

ACLA associate may need to Use and/or Disclose a Member's Protected Health Information (PHI) for the purpose of Treatment, Payment or Health Care Operations (TPO). Federal HIPAA privacy regulations do not require Health Plans to obtain a Member's written consent or

Authorization prior to using, disclosing, or requesting PHI for purposes of TPO, therefore, ACLA is not required to seek a Member's authorization to release their PHI for any one of the aforementioned purposes (see ACFC Policy #168.227, *General Policy – Use and Disclosure of Protected Health Information without Member Consent or Authorization*).

ACLA Associates may not Use, request or Disclose to others any PHI that is more than the Minimum Necessary to accomplish the purpose of the use, request, or disclose (with certain exceptions as outlined in ACFC Policy #168.217, *Minimum Necessary Rule*).ACLA Associates are required to comply with specific policies and procedures established to limit uses of, requests for, or disclosures of PHI to the minimum amount necessary.

ACLA will maintain adequate administrative, technical and physical safeguards to protect the privacy of PHI from unauthorized Use or Disclosure, whether intentional or unintentional, and from theft and unauthorized alteration. Safeguards will also be utilized to effectively reduce the likelihood of Use or Disclosure of PHI that is unintended and incidental to a Use or Disclosure in accordance with the PLAN policies and procedures (see ACLA Policy #161.112, *Safeguards to Protect the Privacy of Protected Health Information*). ACLA will reasonably safeguard PHI to limit incidental Uses and Disclosures. An incidental Use or Disclosure is a secondary Use or Disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a by-product of an otherwise permitted Use or Disclosure (see ACLA Policy #161.112, *Safeguards to Protect the Privacy of Protected Health Information*).

ACLA Associates must follow facsimile guidelines in handling PHI that is transmitted or received in accordance with the company policy (see ACLA Policy #161.110, *Facsimile Machine and Transmission of Protected Health Information*).

PURPOSE

To define a process whereby current member' medical needs are met during the transition of care between MCO's, redirection of care related to changes in provider contracting status and to define consistent processes for continuity of care for members new to ACLA.

DEFINITIONS

See ACLA Policy #UM.001L – Glossary of Terms
See ACFC Policy #168.235 – HIPAA Privacy Definitions

PROCEDURE

A. New members with non-participating practitioners or providers

1. The UM staff will review the transition report from LDH monthly to determine if the member is transitioning from another MCO. Once identified as a transitioning member a request for information on all open prior authorizations will be sent to the relinquishing MCO. The UM staff will enter an authorization for a request for continuation of services meeting the above guidelines into the ACLA authorization system for the continuation of services time period outlined above.

2. If a practitioner/provider identifies that a member has an authorization from Fee-for-Service medical assistance or another medical assistance managed care plan for durable medical equipment, prosthetics, orthotics and medical supplies, ACLA will honor the quantity and scope of services for thirty (30) calendar days from the member's effective date of enrollment with ACLA.

3. ACLA will not deny authorization solely on the basis that the practitioner/provider is not a participating ACLA practitioner/provider.

4. If ACLA is not the primary insurer for the member, the member may choose to stay with the terminated practitioner or provider.

5. All services from non-participating practitioners or providers after the initial thirty (30) days require prior authorization through utilization management. (See ACLA Policy #UM.904L – *Authorization for Out-of-Network Practitioners and Providers*) ACLA's authorization requirement may be waived if the primary insurance is Medicare.

B. Current members when a practitioner/provider terminating from the plan

1. When Provider Network Management staff become aware that a practitioner's/provider's contract is or will be terminated and continuity of care is available through this policy, an ad-hoc report is run to identify all members currently receiving services/products from the practitioner/provider whose contract is terminating and the corresponding head of household, where applicable. For terminating PCPs, a panel report is run, listing all current active members and the corresponding head of household.

2. The member is notified by letter of the following information within fifteen (15) calendar days of the receipt of the termination notice from the provider:

   - The terminated practitioner/provider and the effective date of termination
   - The member's ability to continue services with the terminating practitioner/provider and how to access such services
   - For terminating PCPs, the letter also identifies the name, address and phone number of the new PCP assigned by the plan; a statement explaining the PCP assignment process; and notification that the member may select a different PCP by calling Member Services

- For terminating specialty practitioners, the letter contains a statement advising the member to contact their PCP to discuss any required ongoing medical needs, including transition to another participating specialist

3. If the plan is not the primary insurer for the member, the member may choose to stay with the terminated practitioner/provider. All care/services from nonparticipating practitioners or providers require prior authorization. (See ACLA Policy #UM.904L – *Authorization for Out-of-Network Practitioners and Providers*) ACLA's authorization requirement may be waived if the primary insurance is Medicare.

REFERENCES (Cited Policies and Procedures and Source Documents)

RELATED POLICIES

- ACLA Policy #UM.001L, Glossary of Terms
- ACLA Policy #UM.904L, Authorization for Out-of-Network Practitioners and Providers
- ACLA Policy #161.110, Facsimile Machine and Transmission of Protected Health Information
- ACFC Policy #168.217, Minimum Necessary Rule
- ACLA Policy #168.112, Safeguards to Protect the Privacy of Protected Health Information
- ACFC Policy #168.227, General Policy – Use and Disclosure of Protected Health Information without Member Consent or Authorization

SOURCE DOCUMENTS AND REFERENCES

- 2016 MCO Standards and Guidelines (NCQA): Quality Improvement - Section 9(C)
- LA CCN-P RFP 6.26.3.11, 6.27, 6.29, 6.31

ATTACHMENTS

None

[-End of Policy-]