No. QM-001	Care Coordination and Transition
Effective Date: 7/21/2020	POLICY AND PROCEDURE
Committee Approval: 1/18/2022 Previous Versions: see revision history on last page	
DMHC TAG: Quality Management NCQA: NET 5	

CARE COORDINATION AND TRANSITION POLICY

Primary Care Providers ("PCPs") Assignment

At the time of enrollment in their Health Plan, members select a network primary care physician (PCP) who is responsible for coordinating the member's health care. Canopy Health updates its PCP listing, which is available to members via a provider directory, participating IPA and/or Medical Groups and contracted health plan websites.

If a member does not choose a PCP within 30 days of enrollment, the member's health plan will assign a PCP based on assessment of geographic proximity, PCP capacity, member's age and linguistic needs.

Members may change their PCP thereafter by contacting the Member Services department of their health plan. Changes are made based on the health plan's policy.

Under defined circumstances, the PCP may request and be granted disenrollment of a member from his/her primary care assignment, but must continue to coordinate the member's care for up to 30 days after disenrollment or until the health plan reassigns the member to another PCP to assume continuity of care, whichever date is earlier.

Canopy Health validates that referral systems, timeliness and network adequacy standards are met through its IPAs, medical groups and ancillary providers.

The medical and psychosocial needs of Canopy Health members are addressed by its medical groups/IPAs and by its upstream health plans and their contracted behavioral health providers.

Continuity of Care with Providers Terminating Relationship with Canopy Health

When a Canopy Health practitioner terminates from or is terminated by a delegated IPA, the IPA will inform Canopy Health and the health plans. When the terminating provider is a specialist or has a specialty practice, the delegated IPA manages the continuity of care of all members affected.

At least 30 days prior to the termination effective date, the delegated IPA must:

- notify members affected by a specialist or specialty practice and
- offer continuity and coordination of care for members requesting this when the member has a qualifying condition (see below).

Current Canopy Health members are entitled to continue care with providers who are terminating their relationship with Canopy Health and its IPAs when the member:

1. requests continuity of care from the upstream health plan and
2. has been receiving care from that provider for either
    a. an acute or serious chronic condition that requires ongoing treatment for up to 90 days after the provider's contract termination or
    b. pregnancy, including postpartum services.

Canopy Health through its delegated IPA Utilization Management departments handles these continuity of care requests for current members with Canopy Health providers who are terminating their contract. Those Utilization Management departments review requests, issue and communicate authorization decisions following standard procedures. Each delegated medical group/IPA is responsible for maintaining procedures and systems for interdepartmental notification of

potential contract and provider terminations.

Continuity of Care for Members leaving Canopy Health

Working with Canopy Health's medical groups/IPAs and upstream health plans, Canopy Health will also facilitate safe planned and unplanned transfers of care from Canopy Health to non-Canopy Health providers, such as when members' health plan eligibility ends.

Continuity of Care for New Canopy Health Members

New Canopy Health members may request to continue care with a non-Canopy Health provider with whom they had previously established care. Such requests are completed by members via the forms that are available through each Health Plan's website. Members submit this form to their health plan, which then renders the decision about approving that request and informs the Canopy Health delegated medical group/IPA about that decision.

When the health plan authorizes the member to continue with a non-Canopy Health provider, the member's IPA Utilization Management Department issues the necessary authorization, using its established processes including member and provider notification and following DMHC timeliness standards.

Health problems or conditions that may qualify a new Canopy Health member for Continuity of Care with a provider outside Canopy Health's network under DMHC requirements include the following:

Conditions	Applicable Treatment Period
Acute Condition, including inpatient care (for example, pneumonia)	As long as the condition lasts
Serious Chronic Condition (for example, severe diabetes or heart disease)	No more than 12 months. Usually until a course of treatment is completed and the treating physician can safely transfer care to an in-network physician

Pregnancy	During pregnancy and immediately after the delivery through the post-partum period
Terminal Illness	As long as the person lives
Care of a Child under age 3 years old	For up to 12 months
An already scheduled surgery or other procedure (for example, knee surgery or colonoscopy)	The surgery or procedure date must have been authorized and scheduled to occur within 180 days of leaving the health plan
Home health care, including home IV therapy	No more than 12 months. Usually until a course of treatment is completed and the treating physician can safely transfer care to an in-network physician
Durable medical equipment	No more than 12 months. Usually until a course of treatment is completed and the treating physician can safely transfer care to an in-network physician
Rehabilitation programs	No more than 12 months. Usually until a course of treatment is completed and the treating physician can safely transfer care to an in-network physician

Canopy Health may request that the member's previous health plan and/or providers identify members who require specialized coordination of care and services and then facilitate case review with the previous health plan and current Canopy Health parent health plan and providers before the transition of care into Canopy Health.

The behavioral health networks contracted with the parent health plan are responsible to facilitate care transitions for behavioral health services when necessary. Continuity of care applies for members participating in previously approved courses of treatment for mental health or substance abuse.

Communication Between and Among Providers

Canopy Health supports the collaboration among physicians across the Canopy Health alliance and behavioral health care providers contracted by the health plans by the following:

- Encouraging the exchange of effective, timely and confidential patient information
- Helping to coordinate timely access to care across all physicians, facilities and hospitals
- Implementing an interoperability platform that connects multiple EHR systems

Canopy Health has standards and processes for the appropriate sharing of information such as: adequate and timely feedback, consultation and coordination of care between and among medical and mental health providers, general and specialty practitioners and institutions, referring and consulting providers, etc. Established standards and process include communication among and between providers from among the following:

- Different levels of care including: acute inpatient care, acute rehabilitation, skilled nursing care and outpatient care
- Medical providers: medical and surgical physician providers, including PCPs and specialists
- Care coordinators: R. N. case managers and other staff involved in case management for a member from the health plan, medical group or IPA and facilities, and any other delegates offering these services
- IPAs and/or Medical Groups and staff contracted by the member's health plan to coordinate care.
- Behavioral health care including psychiatrists, psychologists, master's level behavioral health care providers, acute inpatient, partial hospitalization, intensive outpatient program and outpatient services are the responsibility of the member's health plan behavioral health care network. To the extent possible, Canopy Health supports the coordination of patient care between medical care and behavioral health care providers and facilities.

All providers must protect patient confidentiality and shall make member's medical

records and other information available in accordance with applicable state and federal law so not to cause undue delay or disruption in care.

Continuity of Care During Transitions to Home or Different Level of Care

When members are medically stable and ready for discharge to home or to a level of care that is not covered under the Health Plan, they must be informed in writing. Care at the current level and facility will continue until the treating provider agrees with the plan for transition and ongoing medical care. If the member disagrees with the plan for discharge to home or transfer to a different level of care, he or she will be advised to contact the Health Plan and ask for an expedited review. The member may stay in the hospital until the review is completed and a decision is rendered, which must occur within three days of the Health Plan receiving the request. The member must be informed that if the Health Plan agrees with the discharge plan, she or he may have to pay the bill for services incurred between the time the review was requested until the decision was rendered. If the member disagrees with the Health Plan's decision, she or he may call the Department of Managed Health Care (DMHC) Help Center (1-888-466-2219).

Monitoring Care Coordination Activities

Canopy Health QM Committee reviews each participating medical group's policies and procedures that ensure that continuity of care needs are addressed; and that members are screened, identified, and referred for care coordination services when they have co-existing medical and behavioral health conditions.

Block transfer of members in the event of IPA and/or Medical Group termination

Canopy Health's upstream health plans submit in electronic format to the DMHC a Block Transfer filing at least seventy-five (75) days prior to the termination or non-renewal of any provider contract with a terminated provider group or a terminated hospital.

Block Transfer filing includes at minimum the following:

A Transition Plan created by Canopy Health that addresses notification requirements, determines the receiving IPA and/or Medical Group, and provides a breakdown of the membership by product; the number of members who will be able to maintain their current PCP relationship through their new Receiving Group; and the PCP-to-PCP transfers required.

A Member Transfer Notification Letter which will be sent to all members assigned to the terminating medical group/IPA upon DMHC approval. This must be sent within 60 days before the termination effective date. The letter advises members of, among other things: the effective date of the termination; their new medical group/IPA assignment (if known at the time of notification); how to change PCPs or medical groups/IPOs; what to do if they receive a bill from a provider; and to call Canopy Health with any questions or continuity of care concerns. The letter must include the following information:

- name of the terminated provider group or terminated hospital and the name of the assigned physician in that provider group;
- explanation that transfer is necessary due to the termination of the contract between Canopy Health and the terminated provider;
- date of the pending contract termination and transfer;
- explanation about member's assignment to a new provider group, options for selecting a physician within a new provider group, and applicable timeframes for the member to select a new provider group.
- notification that the member may select a different network provider by contacting his/her health plan, as outlined in Canopy Health's continuity of care policy and evidence of coverage or disclosure form;
- statement that the member's parent health plan will receive a new member information card from the parent health plan which includes the name, address and telephone number of the new receiving provider group and assigned physician and indicates that this card will be received by a specified later date that precedes the current contract termination date.
- statement that the member may contact his or her contracted health plan's

Customer Service Department to request completion of care for an ongoing course of treatment from a terminated provider. This statement includes either specific conditions that may qualify for such ongoing care or explanation that the member's eligibility depends on factors outlined in Canopy Health's written continuity of care policy and evidence of coverage or disclosure form;

- the Health Plan phone number the member may call for more explanation of rights regarding completion of care.

Revision History:

Version Date	Edited By	Reason for Change
8/13/15	M. Stevens	Creation date
9/29/16	M. Durbin	To add precision and reduce ambiguity
11/18/16	M. Durbin	Clarifies existing language, add supplemental details regarding: roles of different health care providers in care coordination and transition, process of transition of care between in-network and out-of-network providers, process regarding patients discharged to home or to a different level of care that is not covered by the health plan and how a patient may appeal denial of coverage decisions, monitoring of care coordination activities; adds two categories of patients that may qualify for auths of ongoing services with previously authorized providers: newborns through 36 mo and patients with chronic medical conditions
10/26/17	M. Durbin	Updated transition of care between network and non-network providers to add clarity
12/18/17	A. Kmetz	Updated in response to the WHA pre-delegation audit to clarify continuity of care processes
12/19/17	M Durbin	Changed wording about pregnancy; per DMHC, Continuity of Care (CoC) for pregnancy should not have language specifying that the woman must have had her 1st prenatal visit in order to qualify for CoC.
03/13/18	A. Kmetz	Added "communication with health plan section" based on UHC audit feedback.
7/21/20	M. Durbin	Updated wording to reflect upstream health plan responsibilities for continuity of care and block transfer.