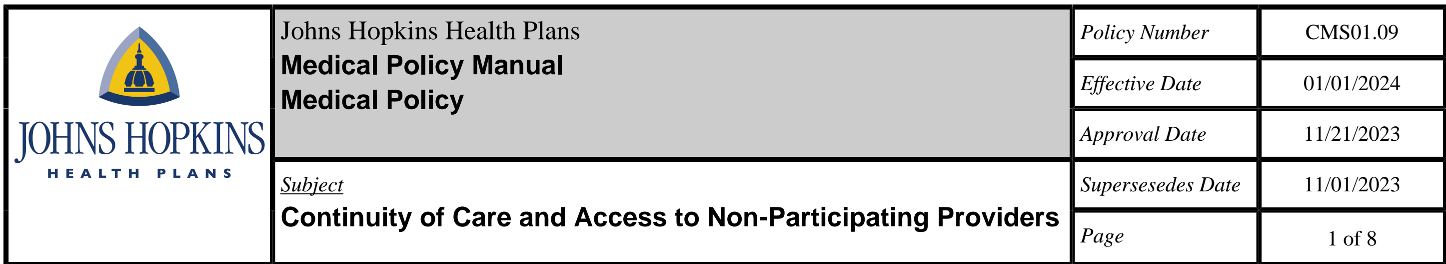

Johns Hopkins Health Plans **Medical Policy Manual** **Medical Policy**	*Policy Number*	CMS01.09
	Effective Date	01/01/2024
	Approval Date	11/21/2023
Subject **Continuity of Care and Access to Non-Participating Providers**	*Supersesedes Date*	11/01/2023
	Page	1 of 8

This document applies to the following Participating Organizations:

Advantage MD | EHP | Johns Hopkins Health Plan of Virginia Inc. (JHHPVA) | Priority Partners

US Family Health Plan

Keywords: continuity, Non Network, Out of Network, termination

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I. ACTION

	New Policy	
X	Revising Policy Number	CMS01.09
	Superseding Policy Number	
	Retiring Policy Number	

II. POLICY DISCLAIMER

Johns Hopkins Health Plans (JHHP) provides a full spectrum of health care products and services for Advantage MD, Employer Health Programs, Johns Hopkins Health Plan of Virginia Inc., Priority Partners, and US Family Health Plan. Each line of business possesses its own unique contract, benefits, regulations, and regulators' clinical guidelines that supersede the information outlined in this policy.

III. POLICY

Cross References:

- PMN.011 Practitioner Termination
- UM69 Single Case Agreement - AdvMD HMO, EHP, PPMCO, and USFHP

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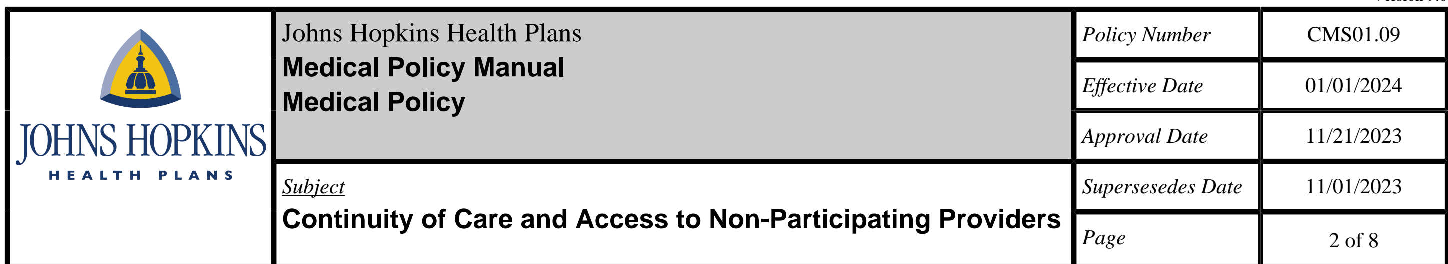

For Advantage MD refer to:

- No Local Coverage Determination (LCD) for Continuity of Care or a National Coverage Determination (NCD) for Continuity of Care (Accessed June 8, 2023).
- Medicare Managed Care Manual, Chapter 4, Benefits and Beneficiary Protections 110.1.2 Significant Changes to Network.
- Medicare Managed Care Manual, Chapter 4, Benefits and Beneficiary Protections 110.1.3 Services for Which MA Plans Must Pay Non-contracted Providers and Supplies.
- Plan specific Advantage MD Evidence of Coverage

For Employer Health Programs (EHP) refer to:

- Plan specific Summary Plan Descriptions

For Johns Hopkins Health Plan of Virginia Inc. (JHHPVA) refer to: Medicare Coverage Database

- No Local Coverage Determination (LCD) for Continuity of Care or National Coverage Determination (NCD) for Continuity of Care (Accessed June 8, 2023)
- Medicare Managed Care Manual, Chapter 4, Benefits and Beneficiary Protections 110.1.2. Significant Changes to Network
- Medicare Managed Care Manual, Chapter 4, Benefits and Beneficiary Protections 110.1.3. Services for Which MA Plans Must Pay Non-contracted Providers and Supplies

For Priority Partners (PPMCO) refer to: Code of Maryland Regulations

- The Maryland Insurance Administration Bulletin 14-22 Continuity of Health Care Notice, Attachment B
- Code of Maryland Regulations (COMAR) 10.67.06.28 Self-Referral Services
- Code of Maryland Regulations (COMAR) 10.09.67.23 Hospice Care Services
- Code of Maryland Regulations (COMAR) 10.67.05.06 Geographical Access Standards
- Priority Partners PPMCO Member Handbook

For US Family Health Plan (USFHP) refer to: Tricare Policy Manual

- USFHP Member Handbook
- TRICARE Operations Manual 6010.62-M, April 1, 2021 Definitions - Continuity of Care
- TRICARE Manual Title 32 National Defense Part 199.17 Access Standards

IV. POLICY CRITERIA

A. Access to Non-Participating Providers for Continuity of Care: Requests to access non-participating providers for continuity of care will be reviewed by a JHHP Medical Director. Access to non-participating providers for continuity of care is subject to regulatory requirements, contractual limitations and exclusions or exceptions as set forth in Plan-specific benefit guidelines.

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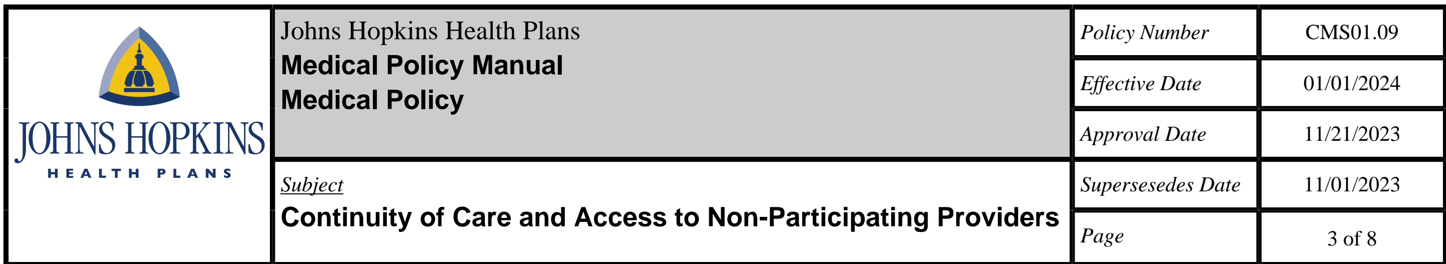

To ensure medically necessary and reasonable continuity of care and integration of services during care transitions, the following guidelines have been established. .
Note: A history of a prior visit, course of treatment, or surgery with a non-participating provider does not always constitute a continuity of care case. The member must be in an active course of treatment at the time of change in health plan or provider termination from the Plan network to meet eligibility requirements for access to non-network providers under the continuity of care provision.

1. Newly Enrolled Members: (*This section is applicable to EHP, & PPMCO)*

   a. Newly enrolled members, who have been receiving covered services from a non-participating provider at the time of the change in health plans on the effective date of contract termination, may be permitted to receive services from the non-participating provider for a limited time.

      i. The duration of time for the care transition to a network provider, except for pregnancy as noted below, is limited to 90 days OR until the active course of treatment is completed, whichever is sooner.
      ii. Newly enrolled members must have been receiving treatment for one of the following conditions at the time of the change in health plans on the effective date of contract termination: (*Refer to Definitions section*)

         i. Acute Condition: Examples of qualifying acute conditions include:
            - bone fractures
            - myocardial infarction
            - other acute trauma or surgery
            - acute exacerbation of a chronic condition (i.e. asthma, CHF, COPD)
         ii. Serious Chronic Condition: Examples of qualifying chronic conditions include:
            - Current cancer treatments (i.e. radiation, chemotherapy, surgery)
            - Staged surgery in process (i.e. cleft palate repair, breast reconstruction after mastectomy)
            - HIV/AIDS
            - Organ transplants
         iii. Pregnancy: Diagnosed and documented by the non-participating provider prior to the newly enrolled member's effective date of coverage. Coverage for the non-participating provider will be for the duration of the pregnancy and the initial postpartum visit.
         iv. Other Condition on Which the Plan and Non-participating Provider Agree
         v. Limited Use of Prior Plan Authorization: (v. *is applicable to PPMCO)*
            Prior authorization from former health plan for health care services that are covered benefits under PPMCO may qualify for access to a non-participating provider. Documentation of prior authorization and notification to the Plan is required. Refer to the Maryland Insurance Bulletin 14-22 in Policy section above.

2. Newly Enrolled Members: (*This section is applicable to Advantage MD and JHHPVA*).
   a. Newly enrolled members switching from another Medicare Plan or new to Medicare, and are currently undergoing an active course of treatment, are provided a minimum of a 90-day transition period, AND;
   b. To ensure continuity of the active course of treatment and prevent disruptions in care, a new preauthorization is not required for new plan enrollees for a period of at least 90 days, AND;

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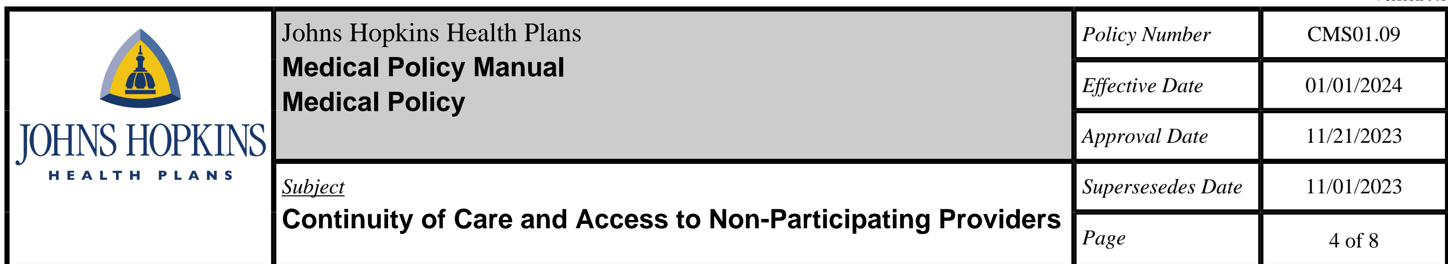

c. These provisions are applicable to new members under an active course of treatment with a provider either in-network or out-of-network with Advantage MD or JHHPVA.

3. Newly Enrolled Members: *(This section is applicable to USFHP)*
   a. Continuation of care by a non-participating specific individual provider may be permitted under the following conditions:
      i. Newly enrolled member is in active treatment for a specific procedure or service performed within the last six months, AND;
      ii. Documentation demonstrates the member's care cannot be safely transferred to a participating provider.

4. Current Members Affected by a Provider Termination from Plan Network: (*This section is applicable to Advantage MD, EHP, JHHPVA, PPMCO, & USFHP)*
   a. Members who are affected by the termination of a primary care practitioner or practice group or a specialist may be allowed continued access to the non-participating practitioner to complete an active course of treatment.
   b. The practitioner's contract must be discontinued for reasons other than due to professional review actions, as defined in the Health Care Quality Improvement Act of 1986.
   c. JHHC will allow affected members continued access to the terminated practitioner for a temporary period of time as described below:
      i. Chronic or Acute Condition: Continuation of treatment through the current period of active treatment, or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition, OR;
      ii. Pregnancy: Continuation of care through the postpartum period for members in their second or third trimester of pregnancy, diagnosed and documented by the non-participating provider.

5. Continuity of Care Termination: (*This section is applicable to Advantage MD, EHP, JHHPVA, PPMCO, & USFHP)*
   In ALL instances, covered services for the continuity of care condition under treatment by the non-participating or terminated provider will be considered complete when ALL of the following have been met:
   a. The member's continuity of care condition under treatment is medically stable, AND;
   b. Consideration is given to the individual member's medical history and the treating providers' recommendation, AND;
   c. There are no clinical contraindications that would prevent a medically safe transfer to a participating provider as determined by a JHHP medical director in consultation as needed with the member, the treating non-participating or terminated provider, and the member's assigned participating provider.

6. Exclusions: (*This section is applicable to Advantage MD, EHP, JHHPVA, PPMCO, & USFHP)*
   Access to non-participating providers under the continuity of care provision excludes the following; this list is not all-inclusive.
   a. Member preference in the absence of one of the above conditions listed 1 - 4 above.
   b. Past healthcare history with a non-participating provider, unless criteria in 1 - 4above are met.

B. Other Access to Non-Participating Providers: (*This section is applicable to Advantage MD, EHP, JHHPVA, PPMCO, & USFHP)*

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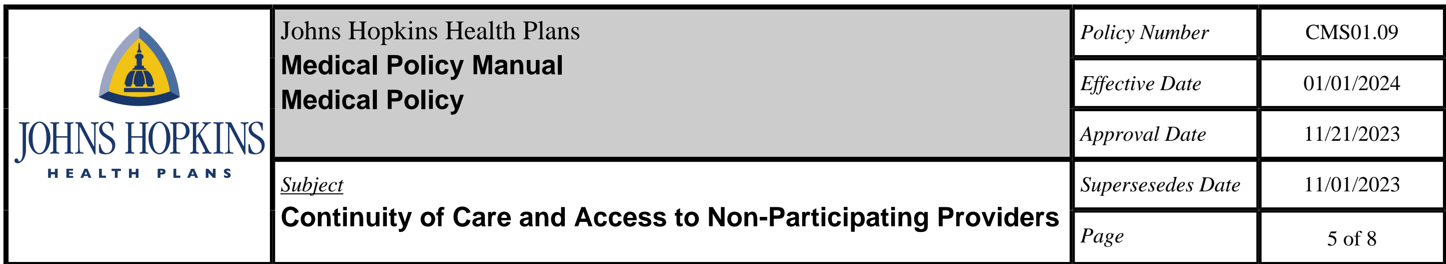

Access to non-participating providers in the absence of a confirmed continuity of care case (as noted in A above) will be reviewed by a JHHP medical director and are subject to regulatory requirements, contractual limitations and exclusions or exceptions as set forth in Plan benefit guidelines which supersede the criteria below. (*Refer to Section A when member is under an active course of treatment*).

1. When benefits are provided under the member's contract, access to non-participating providers may be approved for the following indications:
   a. Covered medically necessary care cannot be provided within the participating network according to the Plan's travel access standard and/or wait time standard.
   b. Member requires inpatient discharge and medical condition or body habitus precludes transfer to a participating facility. Documentation of attempted placement at participating facilities is required.
   c. Member requires a very specialized covered service that is not available within the Plan network, or not available timely based on medical necessity.
   d. Covered service/supply determined to be medically necessary can only be provided from a non-participating provider (i.e. sole source provider of a service).
   e. When benefits allow on a case-by-case basis to provide a temporary bridge in care if member is out of the Plan's geographic area and medical condition prohibits access to care from a participating provider.
2. When a covered medically necessary service cannot be provided by a participating provider in the Plan as noted in a-e above when applicable, member cost sharing will be limited to in-network amounts.
3. The duration of time will be determined on a case-by-case basis taking into consideration the members' individual circumstances and medical history, the treating providers' recommendation, and the availability to in-network providers.
4. Requests based on member preference only or a past healthcare history with a non-participating provider, in the absence of a covered, specific medical need that cannot be met by the Plan's participating providers are subject to the contractual limitations and exclusions or exceptions as set forth in Plan benefit guidelines.

V. DEFINITIONS

Active Course of Treatment: Treatment whose discontinuation could cause a recurrence or worsening of a condition being treated and interfere with anticipated outcomes. Typically involves regular practitioner visits to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol (NCQA, 2023).

Active Course of Treatment: Course of treatment means as a prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan (42 CFR 422.112) (*Advantage MD & JHHPVA*).

Acute Condition: A medical or mental health condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration.

Chronic Condition: A medical condition due to disease, illness, or other medical or mental health problem or 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.

Continuity of Care: A process for assuring that care is delivered seamlessly across a multitude of delivery sites and transitions in care throughout the course of a disease (NCQA, 2023).

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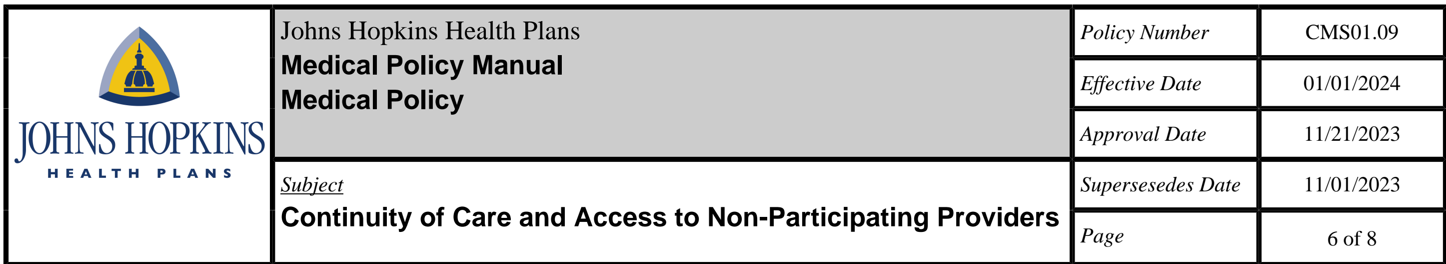

Course of Treatment: Course of treatment means as a prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan (42 CFR 422.112) (*Advantage MD & JHHPVA*).

Participating Provider: For the purposes of this policy, a participating provider refers to a provider in-network with JHHC Plans.

VI. BACKGROUND

Continuity of Care is a health plan process that, under certain circumstances, provides new members with continued care with a former, non-participating provider, including general acute hospitals, while transitioning to a participating provider. It also applies to existing members impacted by a participating provider termination.

The National Committee for Quality Assurance (NCQA) dictates standards for network management, which include notification to members impacted by network provider terminations as well as requirements to assist members with the selection of a new practitioner. Continued access to practitioners is also addressed in this NCQA standard, which requires accredited health plans to allow members to continue treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. This time period is extended for members in their second or third trimester of pregnancy, and continuation of care is required through the post-partum period (NCQA, 2023).

On April 5, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that revises the Medicare Advantage (MA or Part C) regulations to implement changes to several programmatic areas, including access to services. New requirements related to continuity of care have been codified to ensure no delays or gaps in care for new Plan members undergoing an active course of treatment. (CMS Fact Sheet, 2023).

VII. CODING DISCLAIMER

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Note: The following CPT/HCPCS codes are included below for informational purposes and may not be all inclusive. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member's specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee of payment. Other policies and coverage determination guidelines may apply.

Note: All inpatient admissions require preauthorization.

Adherence to the provisions in this policy may be monitored and addressed through post payment data analysis and/or medical review audits
Advantage MD: Regulatory guidance supersedes JHHP Medical Policy. If there are no statutes, regulations, NCDs or LCDs, LCAs, or other CMS guidelines, apply the Medical Policy criteria.
Employer Health Programs (EHP): Specific Summary Plan Descriptions (SPDs) supersedes JHHP Medical Policy. If there are no criteria in the SPD, apply the Medical Policy criteria

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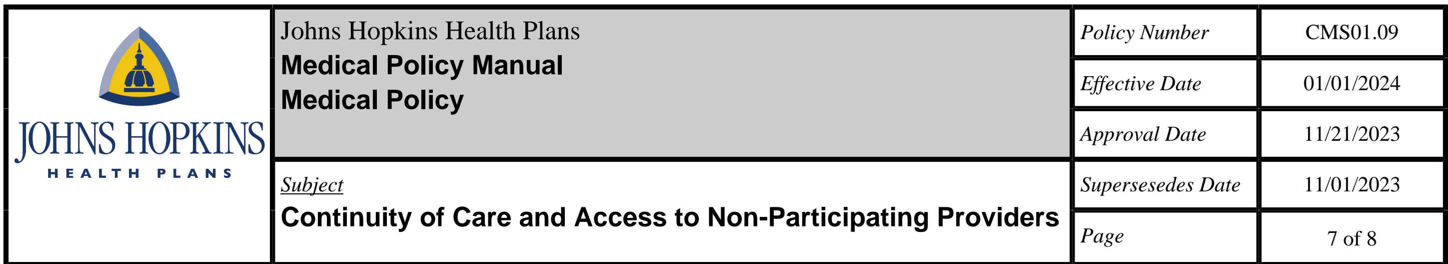

Johns Hopkins Health Plan of Virginia Inc. (JHHPVA): Regulatory guidance supersedes JHHP Medical Policy. If there are no statutes, regulations, NCDs or LCDs, LCAs, or other CMS guidelines, apply the Medical Policy criteria.
Priority Partners (PPMCO): Regulatory guidance supersedes JHHP Medical Policy. If there are no criteria in COMAR regulations, or other State guidelines, apply the Medical Policy criteria.
US Family Health Plan (USFHP): Regulatory guidance supersedes JHHP Medical Policy. If there are no TRICARE policies, or other regulatory guidelines, apply the Medical Policy criteria.

VIII. CODING INFORMATION

CPT® CODES ARE FOR INFORMATIONAL PURPOSES	
CPT® CODES	**DESCRIPTION**
	Multiple Codes

HCPCS CODES ARE FOR INFORMATIONAL PURPOSES	
HCPCS CODES	**DESCRIPTION**
	Multiple Codes

IX. REFERENCE STATEMENT

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins Health Plans (JHHP) Medical Policy Team during the development and implementation of this medical policy. The Medical Policy Team will continue to monitor and review any newly published clinical evidence and revise the policy and adjust the references below accordingly if deemed necessary.

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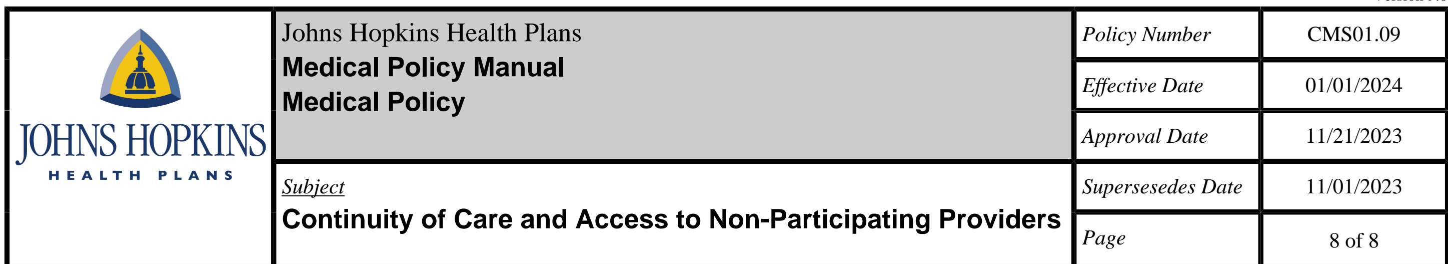

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XI. APPROVALS

Historical Effective Dates: 12/02/2016, 10/01/2018, 11/1/2021, 11/1/2022, 11/1/2023, 01/01/2024

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