PROVIDER*Update*

Health Net®

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Continuity of Health Care Coverage

Senate Bill (SB) 133, effective January 1, 2018, requires all plans to give notice to participating providers regarding members' rights to continuity of care and the process for requesting it. This requirement applies to new enrollees, termination of prior coverage and when a health plan is withdrawn from any portion of the market for a currently enrolled health plan member.

Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) provide for continuity of care or transition of care for new and existing members.

OVERVIEW

Under certain circumstances, new members may maintain their current providers and service authorizations at the time of enrollment in a Health Net plan, even if their provider is not a participating provider or is not contracting with the participating physician group (PPG).

New members who have been receiving care that meets certain criteria may continue with their existing out-of-network providers for up to 12 months. A member may also request approval to complete care if a provider leaves the network. Covered services are provided for the period of time necessary to complete a course of treatment and to arrange for safe transition of care to another provider. Health Net makes the determination in consultation with the member and the terminated provider or nonparticipating provider, and consistent with good professional practice.

At any time, members may change their providers regardless of whether a continuity of care relationship has been established.

CONTINUITY OF CARE CRITERIA

Member requests for continuity of care assistance must meet certain criteria:

- There are no documented quality-of-care issues, or state or federal exclusion requirements where it is determined that the provider is ineligible to continue providing services to Health Net members.
- Compensated rates and methods of payment are the same as those currently used by Health Net or the PPG unless a letter of agreement or letter of understanding is executed.
- Copayments, deductibles or other cost-sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same the member would pay if receiving care from a participating provider.

The following conditions are eligible for continuity of care:

- Acute condition – a sudden onset of symptoms due to an illness, injury, or other medical problem.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ● HMO/POS/HSP
- ● PPO
- ● EPO
- ○ Medicare Advantage (HMO)
- ○ Medi-Cal
  - ○ Kern
  - ○ Los Angeles
    - ○ Molina
  - ○ Riverside
  - ○ Sacramento
  - ○ San Bernardino
  - ○ San Diego
  - ○ San Joaquin
  - ○ Stanislaus
  - ○ Tulare

PROVIDER SERVICES
provider_services@healthnet.com

EnhancedCare PPO (IFP)
1-844-463-8188
provider.healthnetcalifornia.com
EnhancedCare PPO (SBG)
1-844-463-8188
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Health Net Employer Group HMO, POS, HSP, PPO, & EPO
1-800-641-7761
provider.healthnet.com
Individual Family Plan
1-888-926-2164
provider.healthnetcalifornia.com

PROVIDER COMMUNICATIONS
provider.communications@healthnet.com
fax 1-800-937-6086

- Serious chronic condition – a medical condition due to a disease, illness, or other medical problem or medical disorder, not to exceed 12 months from the member's effective date of coverage.
- Pregnancy – for the duration of the pregnancy and the immediate postpartum period.
- Terminal illness – an incurable or irreversible condition that has a high probability of causing death within one year or less. Continuity of care applies for the duration for the terminal illness.
- Newborn care – birth to 36 months, not to exceed 12 months from the member's effective date of coverage under the plan.
- Surgery or a procedure scheduled by a provider that is authorized by the member's prior health plan as a documented course of treatment.
- Behavioral health conditions – all acute, serious or chronic mental health conditions, including treatment for children diagnosed with autism spectrum disorder (ASD). These services include applied behavioral analysis (ABA) – for up to 12 months.

EXCEPTIONS

Some of the circumstances where continuity of care is not available are:

- Services are not a covered benefit of the plan.
- Out-of-network provider does not agree to the utilization management policies and compensation rates.
- Good faith efforts have been made to contact the provider and the provider has not responded to Health Net within 30 calendar days.
- A new member voluntarily chose to change health plans.
- A new member undergoing a course of treatment under an individual agreement with the provider on the effective date of coverage, unless the member's prior individual health plan was terminated by the health insurer. Self-attestation as proof of an individual agreement if not sufficient. The member must provide proof of a relationship and meet the other continuity of care requirements.
- Provider type or service is: durable medical equipment (DME), transportation, other ancillary services, or carved-out services.

REQUESTING CONTINUITY OF CARE

New and existing members, their authorized representatives on file with Health Net, or their providers may request continuity of care directly from Health Net by completing a *Continuity of Care Assistance* form and submitting it to Health Net Member Services or by contacting the Customer Contact Center at the telephone number on the member's Health Net identification card. The form is available on provider.healthnet.com under *Provider Library > Forms > Continuity of Care Assistance*.

Responses to continuity of care requests are reviewed and completed within five business days from the date of receipt and three calendar days if there is an imminent and serious threat to the member's health.

Upon approval of a continuity of care request, the member is notified of the following within 24 hours of the decision:

- Request approval.
- Duration of the continuity of care period.
- Transition process that occurs at the end of the continuity of care period.
- Member's right to choose a different provider from the participating provider network.

Retroactive requests for continuity of care are accepted and approved if all continuity of care requirements are met. The services must have occurred after the member's enrollment in the plan and an existing relationship between the member and provider prior to the member's enrollment into the plan can be demonstrated.

The member is notified 30 calendar days before the end of the continuity of care period regarding the transition of care process.

Participating Physician Group Responsibilities

For delegated PPGs, the completed continuity of care request determination is forwarded to the PPG's utilization management department for implementation of necessary authorizations that must be completed within 30 calendar days for regular requests, 15 calendar days for more immediate cases and three calendar days when there is potential risk of harm to the member.

The PPG utilization management designee is responsible for:

- Issuing the authorizations.
- Explaining the process to the member for requesting continued services beyond the initial authorization.
- Assisting the member with continuing out-of-network services up to the allowable 12 months, when necessary.

The out-of-network provider and member are contacted to confirm that they received authorization from the PPG, and both understand the process for further authorization requests until the end of 12 months.

The PPG case manager is responsible for:

- Working with the out-of-network provider to establish a care plan for the member.
- Notifying the member 30 calendar days prior to the end of the continuity of care period about the transition to a new provider.
- Coordinating the transition with the out-of-network provider.
- Working with the out-of-network provider to ensure they are willing to work with the PPG and Health Net.

ADDITIONAL INFORMATION

Relevant sections of Health Net's provider operations manuals will be revised to reflect the information contained in this update as applicable. Provider operations manuals are available electronically in the Provider Library, located on Health Net's provider website at provider.healthnet.com.

Providers are encouraged to access Health Net's provider portal online, as listed in the table below, for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the applicable Health Net Provider Services Center within 60 days at:

Line of Business	Telephone Number	Provider Portal	Email Address
ENHANCED CARE PPO (IFP)	1-844-463-8188	provider.healthnetcalifornia.com	provider_services@healthnet.com
ENHANCEDCARE PPO (SBG)	1-844-463-8188	provider.healthnet.com	
HEALTH NET EMPLOYER GROUP HMO, POS, HSP, PPO, & EPO	1-800-641-7761	provider.healthnet.com	
INDIVIDUAL FAMILY PLAN	1-888-926-2164	provider.healthnetcalifornia.com	