SMSO Policy Manual
TRANSITION TO OTHER CARE WHEN NEW ON PLAN OR NETWORK CHANGES

Executive Sponsor:	Chief Medical Officer
Issuing Department:	Clinical Management
Gate-Keeper:	Director, HSM Clinical Management

COMPLIANCE STATEMENT:

Enforcement:	All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule:	This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing:	The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare
- ☐ Summa Management Service Organization (SMSO)
- ☒ Apex
- ☒ Summa Insurance Company

Line of Business:

- ☒ Commercial Groups
- ☐ Medicare Supplemental
- ☒ Off-Exchange
- ☒ Medicare
- ☒ On-Exchange
- ☒ Self-Funded

1.0 Purpose:

1.1 To ensure continuity of care and access to needed care when new on plan or experiencing network change.

1.2 To ensure members and providers that the Plan follows and adheres to all federal and state guidelines pertaining utilization and prior authorizations.

2.0 Policy:

2.1 Utilization Management (UM) staff will assist members to obtain transitional care when member is new on plan or experiencing network changes for a period of 30 - 90 days dependent upon line of business, or as appropriate by Medical Director decision, at the in-network benefit level.

2.2 For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance.

2.3 For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate

3.0 Medicare Procedure:

3.1 Members who are new on plan or have experienced a network change such that the provider who has been providing care for the member is now out-of-network may request continuation of care with the provider if he/she feels an active course of treatment with the provider is in progress. UM staff will assess member care needs to determine the need for ongoing services with a particular provider.

3.2 In compliance with CMS regulation 4201_F an active course of treatment is defined as "a member is actively seeing the provider and following a course of treatment".

3.3 If ongoing care needs are identified and to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation, authorization for a minimum of 90 days of treatment with the provider will be approved for Medicare members. An active course of treatment includes taking a physician-administered drug covered under Part B.

3.4 The 90 day transition is a minimum requirement. Therefore, if an active course of treatment is approved by the previous treating provider or plan to last longer than the 90 day minimum, SummaCare may elect to permit the enrollee to finish the course of treatment, which lasts beyond the 90 days, before imposing additional prior authorizations.

3.5 The authorization begins the day enrollment in the new plan becomes effective.

3.6 If an active course of treatment began before enrollment to a new MA plan, the transition period applies for the shorter of the 90-day period, or the end of the active course of treatment.

3.7 Coverage cannot be denied on the basis that the active course of treatment did not receive prior authorization (or was furnished by an out of network provider). Concurrent review should be conducted as necessary to review services furnished against permissible coverage criteria when determining payment.

3.8 If ongoing care needs (course of treatment) are not identified, notification of denial or discontinuation of service may include coverage of alternate care services, as appropriate.

3.9 UM staff will educate members about alternatives for continuing care including how to obtain care, as appropriate.

3.10 UM staff will also evaluate or refer the member to care management as necessary who can evaluate the member's eligibility for public benefit programs and other community services.

4.0 Commercial, MarketPlace, Self-Funded Procedure:

4.1 Members who are new on plan or have experienced a network change such that the provider who has been providing care for the member is now out-of-network must request continuation of care with the provider if he/she feels an active course of treatment with the provider is in progress. UM staff will assess member care needs to determine the need for ongoing services with a particular provider.

4.2 If ongoing care needs are identified and to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation, authorization for a minimum of 60 days of treatment with the provider will be approved for Commercial Fully Insured and Self Insured members, and 30 days for Commercial Marketplace on the Exchange members.

4.3 In the case of pregnancy, continuation of care through the postpartum period for members in their second or third trimester of pregnancy may be available.

4.4 If ongoing care needs (course of treatment) are not identified, notification of denial or discontinuation of service may include coverage of alternate care services, as appropriate.

4.5 UM staff will educate members about alternatives for continuing care including how to obtain care, as appropriate.

4.6 UM staff will also evaluate or refer the member to care management as necessary who can evaluate the member's eligibility for public benefit programs and other community services.

4.7 Jacquie Potelicki, Director, HSM Clinical Management, has the authority and responsibility for the activities in this policy or procedure.

4.8 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

4.8.1 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

5.0 References:

5.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

5.1.1 NCQA NET 5, Element B

5.1.2 CMS Federal Regulation § 422.112(b)(8)(i)(B)

5.2 Are there any references to other documents, regulations, or intranet locations?

5.2.1 None

5.3 Are there other policies that work in conjunction with this policy?

5.3.1 None

5.4 Replaces (if applicable):

5.4.1 None

6.0 Definitions:

6.1 Active course of treatment: defined by CMS as a course of treatment in which a patient is actively seeing a provider and following the course of treatment.

7.0 Key Words or Aliases (Optional):

7.1 Transition to other care when new on plan or network changes

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