Continuity of Care

Policy Number: BIP023.P
Effective Date: February 1, 2025

Instructions for Use

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Related Policies

None

Federal/State Mandated Regulations

California Health and Safety Code (HSC), Section 1373.96, Continuity of Care

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1373.96&lawCode=HSC

(a) A health care service plan shall, at the request of an enrollee, provide the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.

(b) (1) The completion of covered services shall be provided by a terminated provider to an enrollee who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c).

(c) The health care service plan shall provide for the completion of covered services for the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) (A) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical 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. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice.

(B) Completion of covered services under subparagraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3) (A) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(B) For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(6) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

(d) (1) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

(2) Unless otherwise agreed upon by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(e) (1) The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

(2) Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f) The amount of, and the requirement for payment of, 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 as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g) If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h) This section does not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(i) This section does not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. Except as provided in subdivision (l), this section shall not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition described in subdivision (c).

(j) Except as provided in subdivision (l), this section does not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(k) The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. This section does not preclude a plan from providing continuity of care beyond the requirements of this section.

(l) (1) A health care service plan shall, at the request of a newly covered enrollee under an individual health care service plan contract, arrange for the completion of covered services as set forth in this section by a nonparticipating provider for one of the conditions described in subdivision (c) if the newly covered enrollee meets both of the following:

(A) The newly covered enrollee's prior coverage was terminated under paragraph (5) or (6) of subdivision (a) of Section 1365 or subdivision (d) or (e) of Section 10273.6 of the Insurance Code, which includes circumstances when a health benefit plan is withdrawn from any portion of a market.

(B) At the time his or her coverage became effective, the newly covered enrollee was receiving services from that provider for one of the conditions described in subdivision (c).

(2) The completion of covered services required to be provided under this subdivision apply to services rendered to the newly covered enrollee on and after the effective date of his or her new coverage.

(3) A violation of this subdivision does not constitute a crime under Section 1390.

(m) Notice as to the process by which an enrollee may request completion of covered services pursuant to this section shall be provided in every disclosure form as required under Section 1363 and in any evidence of coverage issued after January 1, 2018. A plan shall provide a written copy of this information to its contracting providers and provider groups. A plan shall also provide a copy to its enrollees upon request. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any termination of coverage notice sent in the circumstances described in subdivision (l).

(n) The following definitions apply for the purposes of this section:
  (1) "Individual provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.
  (2) "Maternal mental health condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
  (3) "Nonparticipating provider" means a provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.
  (4) "Provider" shall have the same meaning as set forth in subdivision (i) of Section 1345.
  (5) "Provider group" means a medical group, independent practice association, or any other similar organization.

(Amended by Stats. 2019, Ch. 776, Sec. 1. (AB 577) Effective January 1, 2020.)

Health Plan Note: In accordance with UnitedHealthcare's evidence of coverage, a member's new carrier becomes responsible for all healthcare services as of the member's first date of eligibility with the plan. The Medical Group/IPA and Capitated Hospital become responsible to authorize and direct a member's care and pay claims as of the member's first date of eligibility with the new health plan, regardless of the member's inpatient status.

The above requirements do not apply to a new member who is offered an out-of-network option or who had the option to continue with his/her previous health plan or provider and voluntarily chose to change health plans.

HSC Section 1399.63, Required Coverage (Only Applies to an Employer That is No Longer in Business)

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1399.63.

(a) Any carrier providing replacement coverage with respect to hospital, medical or surgical expense or service benefits within a period of 60 days from the date of discontinuance of a prior contract or policy providing such hospital, medical or surgical expense or service benefits shall immediately cover all employees and dependents who were validly covered under the previous contract or policy at the date of discontinuance, including all former employees entitled to continuation coverage under Section 1373.621, who are within the definitions of eligibility under the succeeding carrier's contract and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active full-time employment or hospital confinement or pregnancy. However, with respect to employees or dependents who are totally disabled on the date of discontinuance of the prior carrier's contract or policy and entitled to an extension of benefits pursuant to subdivision (b) of Section 1399.62, or pursuant to subdivision (d) of Section 10128.2 of the Insurance Code, the succeeding carrier is not required to provide benefits for services or expenses directly related to any conditions which caused the total disability.

(b) Except as otherwise provided in subdivision (a), until an employee or dependent entitled to coverage under a succeeding carrier's contract pursuant to subdivision (a) of this section qualifies for full benefits by meeting all effective date requirements of the succeeding carrier's contract, the level of benefits shall not be lower than the benefits provided under the prior carrier's contract or policy reduced by the amount of benefits paid by the prior carrier. Such employee or dependent shall continue to be covered by the succeeding carrier until the earlier of the following dates:
  (1) The date coverage would terminate for an employee or dependent in accordance with the provisions of the succeeding carrier's contract, or
  (2) In the case of an employee or dependent who was totally disabled on the date of discontinuance of the prior carrier's contract or policy and entitled to an extension of benefits pursuant to subdivision (d) of Section 10128.2 of the Insurance Code or subdivision (b) of Section 1399.62, the date the period of extension of benefits terminates or, if the prior carrier's contract or policy is not subject to this article, the date to which benefits would have been extended had the prior carrier's contract or policy been subject to this article.

(c) Except as otherwise provided in this section, and except to the extent that benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those employees, former employees entitled to continuation coverage under Section 1373.621, and dependents validly covered under the prior carrier's contract or policy on the date of discontinuance.

(d) In a situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall furnish a statement of benefits available or pertinent information, sufficient to permit verification of the benefit determination by the succeeding carrier.
(e) For purposes of subdivision (a), a succeeding carrier's coverage shall not exclude any dependent child who was covered by the previous carrier solely because the plan member does not provide the primary support for that dependent child.
(f) Except to the extent that benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in the succeeding carrier's contract, where an employee changes carriers due to a change in employment or other circumstances, that would operate to reduce or exclude benefits for the following congenital craniofacial anomalies: cleft lip and palate (as defined in ICD-9-CM Diagnosis Code 749, International Classification of Diseases, 9th Revision, Clinical Modification, Volume 1, Second Edition, September, 1980), acrocephalosyndactyly (as defined in ICD-9-CM Diagnosis Code 755.55, cranio only), and other congenital musculoskeletal anomalies (as defined in ICD-9-CM Diagnosis Code 756.0), on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract, shall be applied to those employees, former employees entitled to continuation coverage under Section 1373.621, and dependents validly covered under the prior carrier's contract or policy on the date the prior contract or policy terminated when payment or services had been commenced by the previous carrier. That succeeding coverage shall otherwise be subject to all other provisions of the contract between the insured and the succeeding carrier. Nothing in this subdivision shall be construed to limit or otherwise affect any obligation of a succeeding carrier to provide benefits for a condition not specified in this subdivision, where expressly or impliedly required by other provisions of this chapter; this subdivision is not intended to affect the construction of the language of any other provision of this chapter.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine coverage eligibility.

Continuity of Care

Continuity of care may be covered in the following circumstances, when criteria are met:
- A newly enrolled member of UnitedHealthcare, receiving services from an out-of-network provider, or
- An existing member of UnitedHealthcare receiving care from a terminated provider, or
- An existing member of UnitedHealthcare transitioning from one plan to another with a provider that is not in-network.

Continuity of Care for New Members at the Time of Enrollment

Under certain circumstances, as a new member of UnitedHealthcare, a member may be able to continue receiving services from an out-of-network provider to allow for the completion of covered health care services provided by an out-of-network provider, if they were receiving services from that provider at the time the member's coverage became effective, for one of the continuity of care conditions as limited and described below.

Continuing Care With a Terminated Provider for Members

Under certain circumstances, a member may be eligible to continue receiving care from a terminated provider to ensure a smooth transition to a new network provider and to complete a course of treatment with the same terminated provider or to maintain the same terminating provider.

The care must be medically necessary, and the cause of termination by UnitedHealthcare or the network medical group also has to be for a reason other than a medical disciplinary cause, fraud, or any criminal activity.

For a member to continue receiving care from a terminated provider, the following conditions must be met:
- A request for continuity of care services from a terminated provider must be submitted to UnitedHealthcare within 30 calendar days from the date the provider is terminated for review and approval;
- The requested treatment must be a covered health care service under this health plan;

- The terminated provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the provider contract related to continuity of care;
- The terminated provider must agree in writing to be compensated at rates and methods of payment similar to those used by UnitedHealthcare or network medical groups/Independent Practice Associations (NMG/IPA) for current network providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider.

Covered health care services provided by a terminated provider to a member who at the time of the network provider's contract termination was receiving services from that network provider for one of the continuity of care conditions, as limited and described below, will be considered complete when:

- The member's continuity of care condition under treatment is medically stable; and
- There are no clinical contraindications that would prevent a medically safe transfer to a network provider as determined by a UnitedHealthcare medical director in consultation with the member, the terminated network provider and, as applicable, the member's receiving network provider.

Continuity of Care (COC) for Members Transitioning From One Plan to Another Plan

Members transitioning from one plan to another plan with a provider that is not in-network may be eligible for COC. The member can apply for COC. Refer to the continuity of care section in the member's evidence of coverage (EOC)/schedule of benefit (SOB) for detailed instructions on applying for COC.

Continuity of Care Condition(s)

The completion of covered health care services will be provided by: (i) a terminated provider to a member who, at the time of the network provider's contract termination, was receiving covered health care services from that network provider, or (i) out-of-network provider for newly enrolled member who, at the time of his or her coverage became effective with UnitedHealthcare, was receiving covered health care services from the out-of-network provider, for one of the continuity of care conditions, as limited and described below:

- **An Acute Condition**
  A medical condition, including medical and mental health, that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered health care services will be provided for the duration of the acute condition.

  Refer to the member's Evidence of Coverage (EOC), Section 5. Your Medical Benefits, and to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for USBHPC mental health and substance-related and addictive disorder services.

- **A Serious Chronic Condition**
  A medical condition due to disease, illness, or other medical or mental health problem or medical or mental health 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. Completion of covered health care services will be provided for the period of time needed to complete the active course of treatment and to arrange for a clinically safe transfer to a network provider, as determined by a UnitedHealthcare medical director in consultation with the member, and either (i) the terminated provider or (ii) the out-of-network provider and as consistent with good professional practice. Completion of covered health care services for this condition will not exceed twelve (12) months from the agreement's termination date or 12 months from the effective date of coverage for a newly enrolled member.

  Note: U.S. Behavioral Health Plan, California (USBHPC) will coordinate continuity of care for members requesting continued care with a terminated or out-of-network provider for mental health care and substance-related and addictive disorder services.

- **A Pregnancy and/or A Maternal Mental Health Condition**
  - **A Pregnancy:** the three trimesters of pregnancy and the immediate postpartum period. completion of covered health care services will be provided for the duration of the pregnancy.
  - **A Maternal Mental Health Condition**: A mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. The member's current provider shall provide written documentation of a maternal mental health condition diagnosis from the member's treating health care provider. Completion of covered services will be provided not to exceed

12 months from the diagnosis of the maternal mental health condition, or from the end of pregnancy, whichever occurs later, and to arrange for a safe transfer to a provider. the transfer shall be determined by UnitedHealthcare in consultation with the member and the terminated provider and consistent with good medical practice.

- **A Terminal Illness**
  An incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered health care services will be provided for the duration of the terminal illness.

- **The Care of a Newborn**
  Services provided to a child between birth and age thirty-six (36) months. Completion of covered health care services will not exceed twelve (12) months from the: (i) provider agreement termination date, or (ii) the newly enrolled member's effective date of coverage with UnitedHealthcare, or (iii) extend beyond the child's third (3rd) birthday.

- **Surgery or Other Procedure**
  Performance of a surgery or other procedure that has been authorized by UnitedHealthcare or the member's assigned network provider as part of a documented course of treatment and has been recommended and documented by the: (i) by the provider to occur within 180 days of the contract's termination date, or (ii) within 180 days of the effective date of coverage for a newly covered enrollee .This includes nonelective surgery from a provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.

- **Inpatient or Institutional Care**
  Unless otherwise specified above, continuity of care will continue until the earlier of: (i) ninety (90) days from the date of notice of the right to continuation of care; or (ii) the date the member is no longer a continued care patient with respect to such provider or facility.

Not Covered

Continuity of care is not covered except as mentioned above in the *Federal/State Mandated Regulations*, *State Market Plan Enhancements* and *Covered Benefits* sections. Examples include but are not limited to:

- Routine exams, vaccinations, and health assessments.
- Chronic conditions that are stable (except as required by state law).
- Minor illnesses such as colds, sore throats, and ear infections.
- Care for any condition that exceeds 12 months beyond the provider's termination date or the member's effective date of coverage (This limit does not apply to continuity of care for terminal illness).

Policy History/Revision Information

Date	Summary of Changes

02/01/2025	**Covered Benefits**
	Continuity of Care
	• Added language to indicate continuity of care may be covered in the following circumstances when criteria are met:
	  ○ A newly enrolled member of UnitedHealthcare receiving services from an out-of-network provider; or
	  ○ An existing member of UnitedHealthcare receiving care from a terminated provider; or
	  ○ An existing member of UnitedHealthcare transitioning from one plan to another with a provider that is not in-network
	Continuity of Care for New Members at the Time of Enrollment
	• Added language to indicate a new member of UnitedHealthcare may be able to continue receiving services from an out-of-network provider, under certain circumstances, to allow for the completion of covered health care services provided by an out-of-network provider, if they were receiving services from that provider at the time the member's-coverage became effective, for one of the continuity of care conditions as limited and described [in the policy]
	Continuing Care With a Terminated Provider for Members
	• Added language to clarify covered health care services provided by a terminated provider to a member who at the time of the network provider's contract termination was receiving services from that network provider for one of the continuity of care conditions, *as limited and described [in the policy]*, will be considered complete when [the listed criteria are met]

Date	Summary of Changes
	Continuity of Care Condition(s) • Revised coverage guidelines for: Acute Condition ○ Replaced instruction to "refer to Section 5, Your Medical Benefits and to the behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form* for U.S. Behavioral Health Plan, California (USBHPC) *for a description of* mental health" with "refer to *the member's Evidence of Coverage (EOB)* Section 5, Your Medical Benefits and to the behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form* for U.S. Behavioral Health Plan, California (USBHPC) mental health *and substance-related and addictive disorder services*" Serious Chronic Condition ○ Relaced language indicating "USBHPC will coordinate continuity of care for members requesting continued care with a terminated or out-of-network provider for *behavioral health services*" with "USBHPC will coordinate continuity of care for members requesting continued care with a terminated or out-of-network provider for *mental health care and substance-related and addictive disorder services*" Pregnancy and/or Maternal Mental Health Condition ○ Revised language to indicate: ▪ A pregnancy is the three trimesters of pregnancy and the immediate postpartum period; completion of covered health care services will be provided for the duration of the pregnancy ▪ A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery – The member's current provider shall provide written documentation of a maternal mental health condition diagnosis from the member's treating health care provider – Completion of covered services will be provided not to exceed 12 months from the diagnosis of the maternal mental health condition, or from the end of pregnancy, whichever occurs later, and to arrange for a safe transfer to a provider; the transfer shall be determined by UnitedHealthcare in consultation with the member and the terminated provider and consistent with good medical practice Surgery or Other Procedure ○ Replaced language indicating "performance of a surgery or other procedure that has been authorized by UnitedHealthcare or the member's assigned network provider as part of a documented course of treatment and has been recommended and documented by the *(i) terminating* provider to occur within 180 *calendar* days of the *agreement's* termination date, or *(ii) out-of-network provider to occur* within 180 calendar days of the newly *enrolled member's* effective date of coverage *with UnitedHealthcare* [is covered]" with "performance of a surgery or other procedure that has been authorized by UnitedHealthcare or the member's assigned network provider as part of a documented course of treatment and has been recommended and documented by the provider to occur *(i)* within 180 days of the *contract's* termination date, or *(ii)* within 180 days of the effective date of coverage for a newly *covered enrollee* [is covered]"; *this includes nonelective surgery from a provider, including receipt of postoperative care from such provider or facility with respect to such a surgery*" **Not Covered** • Added list of examples of non-covered continuity of care (not all inclusive): ○ Routine exams, vaccinations, and health assessments ○ Chronic conditions that are stable (except as required by state law) ○ Minor illnesses such as colds, sore throats, and ear infections ○ Care for any condition that exceeds 12 months beyond the provider's termination date or the member's effective date of coverage; this limit does not apply to continuity of care for terminal illness **Supporting Information** • Archived previous policy version BIP023.O

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.