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CENTRAL HEALTH MEDICARE PLAN

Policies and Procedures

Part C Medicare Advantage (MA) Continuity and Coordination of Care Processes			
POLICY #	**MED-037**	**CURRENT VERSION**	**4**
POLICY OWNER	**Beth Sharma**	**CURRENT VERSION EFFECTIVE DATE**	**December 14, 2023**
DEPARTMENT	**Clinical Services**	**ORIGINAL / INITIAL EFFECTIVE DATE**	**January 1, 2020**

DEFINITIONS

1. **Care Setting:** The provider or place where the Member receives health care and health-related services. In any setting, a designated practitioner has ongoing responsibility for the Member's medical care.[1]

2. **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 the disease process.[2]

3. **Coordination of Care:** Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.[3]

4. **Member (Member of Bright HealthCare's Plan, or "Plan Member"):** means a person with Medicare who is eligible to receive covered services, who has enrolled in Bright Health's plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

5. **Medication Reconciliation:** The process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders. It is also important to verify whether the patient is actually taking the medication as prescribed or instructed, as sometimes this is not the case.[4]

6. **Social determinants of health (SDOH):** The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are

[1] NCQA 2020 Accreditation Standards and Guidelines, Appendix 5 – Glossary
[2] NCQA 2020 Accreditation Standards and Guidelines, Appendix 5 – Glossary
[3] Agency for Healthcare Research and Quality (AHRQ) https://www.ahrq.gov/topics/care-coordination.html#accordions

[4] Institute for Healthcare Improvement (IHI)
http://www.ihi.org/topics/ADEsMedicationReconciliation/Pages/default.aspx

mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.[5]

7. **Transition:** Movement of individuals between care settings (e.g., from home to hospital) as their condition and care needs change during the course of a chronic or acute illness.[6]

PURPOSE

To outline Bright HealthCare's processes for internal and external care coordination to promote continuity of care and reduce the potential for risks to patient safety.

SCOPE

This policy applies to all Bright HealthCare departments, staff Members, and delegates under contract with Bright HealthCare to support Bright HealthCare's Medicare Advantage (MA) plans. This policy further applies to Bright HealthCare and all its affiliates.

POLICY

Bright HealthCare identifies and acts upon opportunities to support Member needs for continuity and coordination of care, to promote effective care transitions and to promote optimal Member health outcomes.

PROCEDURES

1. Bright HealthCare Utilization Management Clinicians may be informed about planned (e.g. upcoming inpatient admission) or unplanned (e.g. emergency department visit) care transitions via the following mechanisms:
   A. Notification from Utilization Management (UM) and/or the care management department of pre-authorized services (e.g. outpatient services for ambulatory surgery and planned inpatient admission);
   B. Daily reports from network and non-network facilities which includes information about acute inpatient admissions (e.g., hospital, skilled nursing facility, and rehabilitation facility). These reports may also include information about Member discharge, emergency department (ED) visit and/or readmission;
   C. Calls from Members and/or their family or guardian; and
   D. Notification from facility and/or treating provider via fax, phone or web portal.
2. A DSNP member may request up to 12 months of Continuity of Care with a Provider if a verifiable pre-existing relationship exists with that provider.
3. Care settings and services for which Bright HealthCare provides transition and continuity and coordination of care support may include, but is not limited to:
   A. Member home
   B. Home health care, which may include provision of Durable Medical Equipment (DME). Bright HealthCare must maintain continuity of care by ensuring uninterrupted

[5] World Health Organization (WHO) https://www.who.int/social_determinants/sdh_definition/en/
[6] NCQA 2020 Accreditation Standards and Guidelines, Appendix 5 – Glossary

access to the medically necessary covered DME item, including when the item needs to be repaired or replaced.[7]

C. Care Management services; or
D. Acute care facilities (hospital, SNF, rehabilitation) to include emergency department care
E. Custodial nursing facilities
F. Ambulatory care/surgical centers
G. Primary Care Providers for Dual Members
H. Specialists for Dual Members
I. Select Ancillary Providers, including physical therapy; occupational therapy; reparatory therapy; BHT; and speech therapy providers for Dual Members.

4. For Members who have planned or unplanned transition to a care setting or services, Bright HealthCare's Utilization Management Clinicians and/or Care Managers will work with Members and/or their representative for effective care transitions and optimal clinical outcomes.

5. Utilization Management Clinicians and/or Care Managers will coordinate and collaborate to facilitate services for Members during a care transition which may include:
   A. Offer supporting services by providing contact information, answer questions, discuss and coordination post-discharge plans including referrals for home health or other post-discharge options (ie.g., skilled nursing facility, outpatient rehabilitation), and self-management education regarding current/upcoming procedure/admission/services.
   B. Conduct medication reconciliation, assist in scheduling follow-up visits with primary and specialty care providers, facilitate receiving any needed equipment and/or supplies for the Member.
   C. Evaluate Member's support systems, social determinants of health needs including transportation, food insecurity or housing concerns and make appropriate referrals and advocate for Member as needed.

6. For DSNP members Bright HealthCare will begin to process non-urgent requests within five working days following the receipt of the Continuity of Care request. Additionally, each Continuity of Care request must be completed within the following timelines from the date the MCP received the request:
   A. • 30 calendar days for non-urgent requests;
   B. • 15 calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
   C. As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is an identified risk of harm to the Member).
   D. For Non-DSNP members we will follow Medicare guidelines for continuity of Care timelines.

7. Member Notifications
   A. Bright HealthCare will acknowledge the request within the timeframes specified below, advising the member that the request has been received, the date of receipt and the estimated timeframe for resolution. Bright will notify the member by using the

[7] MMCM Chapter 4 Benefits and Beneficiary Protections, Section 10.12

Member's known preference of communication or by notifying the Member using one of these methods in the following order: telephone call, email and then notice by mail.

i. For non-urgent request, within seven calendar days of the decision or sooner if required for non-DSNP members.
ii. For urgent request, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision.

B. For DSNP members Bright will send a notice by mail to the members within seven calendar days of the continuity of care decision.
   i. The denial notification must include the following:
      1. A statement of the decision
      2. A clear and concise explanation of the reason for denial.
      3. The member's right to file a grievance or appeal.
   ii. The approval notification must include the following:
      1. A statement of the decision
      2. The duration of the Continuity of Care Arrangements.
      3. The process that will occur to transition the Member's care at the end of the Continuity of Care period.
      4. The member's right to choose a different Network Provider.

8. To assure continuity and coordination of care, Members participating in Bright HealthCare's care management programs, the Care Manager may:
   A. Conducts assessments of Member's health condition
   B. Develops, monitors and manages an individualized care plan with the Member and his/her representative, as applicable.
   C. Identifies SDOH issues that create barriers to effective continuity and coordination of care; collaborates with Member and others involved in his/her care to develop interventions to address barriers.
   D. Identifies opportunities to improve continuity and coordination of care by:
      i. Recommending health screenings such as colorectal cancer screening and preventive measures, such as flu shots, as applicable.
      ii. Assisting Members with scheduling appointments for physician visits, testing or other services.
      iii. Following up with Member to ensure that Member received the recommended services.
      iv. Engages internal and external care teams (e.g. Grand Rounds, Interdisciplinary Care Team) for Members that need complex care support and/or support with other issues.

9. If Bright and the OON Provider are unable to reach an agreement because they cannot agree to a rate, or Bright has documented the quality-of-care issues with the provider, Bright must offer the Member a Network Provider alternative. If the member does not make a choice, the Member must be referred to a Network Provider. If the member disagrees with the Continuity of Care determination, the Member maintains the right to file a grievance.
10. In order to maintain the continuity of care of potentially impacted Members for no-cause provider termination,

*Refer to policy *NET-002 Network Adequacy Standards* .[8]

A. Bright HealthCare outreaches and assists Member's in transitioning to new providers to facilitate continuity of care for impacted Members with the no-cause termination of a provider. Outreach may include written, verbal (phone calls), and electronic communication offering to work with Members in locating a new in-network provider.
B. Bright HealthCare will close panels of termed providers to prevent new continuity of care issues from arising.

11. In order to maintain the continuity of care of new members undergoing an active course of treatment prior to enrollment, including those who are new to Medicare, Bright HealthCare shall waive prior authorization requirements for services rendered within 90 days of enrollment, including those for out-of-network providers, provided:
    A. The course of treatment was ordered for the specific individual member for a specific covered medical condition.
    B. The course of treatment is outlined and decided upon ahead of time with the member and the member's licensed healthcare provider.
    C. The member is actively seeing the licensed healthcare provider and following the course of treatment.

REFERENCES/CITATIONS

NCQA 2020 Health Plan Accreditation Standards and Guidelines
Agency for Healthcare Research and Quality (AHRQ)
World Health Organization (WHO) https://www.who.int/social_determinants/sdh_definition/en/
Institute for Healthcare Improvement (IHI)
Medicare Managed Care Manual Chapter 4, Benefits and Beneficiary Protections
NET-002 Network Adequacy Standards
ALL PLAN LETTER 22-032

EXHIBITS/ATTACHMENTS

None

POLICY HISTORY

Initial Approval Date: August 13, 2020
Version 2, Approval Date: August 27, 2021
Version 3, Approval Date: August 11, 2022
Version 4, Approval Date: December 14, 2023

AUTHORIZATION

The following signatory certifies that this policy has been approved by the Policy Review Committee or has received other necessary approval pursuant to the policy CMP-013 Policy Development for implementation by the applicable department.

DocuSigned by:
Elizabeth Sharma 12/14/2023
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Policy Owner

[8] MMCM Chapter 4 Benefits and Beneficiary Protections, Section 110.1.2.2 and Section 100.1.2.3