**Medical Policy**

| Continuity of Care and Transition of Care | |
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| **MEDICAL POLICY NUMBER** | MED_Clin_Ops_014 |
| **CURRENT VERSION EFFECTIVE DATE** | January 1, 2024 |
| **APPLICABLE PRODUCT AND MARKET** | *Individual Family Plan:* All Plans (Excluding CA)<br>*Small Group*: All Plans<br>*Medicare Advantage:* All Plans |

*Brand New Day/Central Health Medicare Plan develops policies and makes coverage determinations using credible scientific evidence including but not limited to MCG™ Health Guidelines, the ASAM Criteria™, and other third party sources, such as peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and expert opinion as relevant to supplement those sources. Brand New Day/Central Health Medicare Plan Medical Policies, MCG™ Guidelines, and the ASAM Criteria™ are not intended to be used without the independent clinical judgment of a qualified health care provider considering the individual circumstances of each member's case. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice. Members may contact Brand New Day/Central Health Medicare Plan Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Brand New Day/ Central Health Medicare Plan policy may contact the Health Plan. Brand New Day/Central Health Medicare Plan policies and practices are compliant with federal and state requirements, including mental health parity laws.*

*If there is a difference between this policy and the member specific plan document, the member benefit plan document will govern. for Medicare Advantage members, Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), govern. Refer to the CMS website at http://www.cms.gov for additional information.*

*Brand New Day/Central Health Medicare Plan medical policies address technology assessment of new and emerging treatments, devices, drugs, etc. They are developed to assist in administering plan benefits and do not constitute an offer of coverage nor medical advice. Brand New Day/Central Health Medicare Plan medical policies contain only a partial, general description of plan or program benefits and do not constitute a contract. Brand New Day/Central Health Medicare Plan does not provide health care services and, therefore, cannot guarantee any results or outcomes. Treating providers are solely responsible for medical advice and treatment of members. Our medical policies are updated based on changes in the evidence and healthcare coding and therefore are subject to change without notice. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). MCG™ and Care Guidelines® are trademarks of MCG Health, LLC (MCG).*

## PURPOSE

The purpose of Continuity of Care and Transition of Care (see definitions below) policy is to ensure the coordination and appropriate continuation of health care when:

- The treating provider of a member with a qualifying condition leaves the Brand New Day/Central Health Medicare Plan network or
- A member with a qualifying condition is new to the Brand New Day/Central Health Medicare Plan and has out of network providers.

## SCOPE

This policy applies to all Brand New Day/Central Health Medicare Plan departments, staff members, and entities under contract with Brand New Day/Central Health Medicare Plan who provide any level of customer service or assistance related to their medical or behavioral health care or access to care for Brand New Day/Central Health Medicare Plan Individual and Family Plans, Small Group Plans, and Medicare Advantage plans in all markets, except California (*for California, refer to MED-087.CA*)

## POLICY/CRITERIA

Brand New Day/Central Health Medicare Plan actively works to establish and implement internal procedures for ensuring a comprehensive approach to providing medical and behavioral health care for Brand New Day/Central Health Medicare Plan members. It is the intent of Brand New Day/Central Health Medicare Plan to meet all applicable state and federal regulatory and accreditation requirements pertaining to continuity and transition of care. This includes applicable requirements that every contract between Brand New Day/Central Health Medicare Plan and a participating provider will include provisions for continuity of care.

Brand New Day/Central Health Medicare Plan has established internal procedures for ensuring a comprehensive approach to monitoring continuity and coordination of medical and behavioral health care for its members. Brand New Day/Central Health Medicare Plan pursues opportunities to improve continuity and coordination of health care for Brand New Day/Central Health Medicare Plan members.

**Continuity of Care (COC):**
Existing members who are under the care of a doctor, hospital or other provider who leaves the Brand New Day/Central Health Medicare Plan network may be eligible for Continuity of Care. When an in-network doctor, hospital or other provider leaves the Brand New Day/Central Health Medicare Plan network, Continuity of Care allows existing members to receive services at in-network coverage levels for specified medical and behavioral conditions for a defined period of time if there are significant clinical reasons preventing immediate transfer of care to an in-network provider.

- Existing members should apply for Continuity of Care within 30 days of being notified that their in-network provider is leaving the Brand New Day/Central Health Medicare Plan network.
- Requests will be reviewed within 10 days of receipt, except for organ transplant requests which will be reviewed within 30 days.
- If existing members are under the care of an in-network provider for one of the medical conditions below and the in-network provider caring for existing members is terminated from the network by Brand New Day/Central Health Medicare Plan or otherwise leaves the network, Brand New Day/Central Health Medicare Plan may arrange, at existing members request and subject to the provider's agreement, for continuation of Covered Health Services rendered by the terminated provider for the time periods shown here:
    - *Acute Condition or Serious Chronic Condition* (see below for examples) that cannot be safely and effectively transferred to an In-Network provider. Treatment by the terminated Provider may continue for up to 3 months.
        - For standard requests, approval will be made in one month increments up to three times.
        - Referrals will be made by the Utilization Management team to Brand New Day/Central Health Medicare Plan ’s Care Management team to assist the member to transition to a contracted Brand New Day/Central Health Medicare Plan provider as appropriate.
    - *High-risk pregnancy* or a *pregnancy that has reached the second or third*

*trimester*. Treatment by the terminated provider may continue until the postpartum services related to the delivery are completed.

This section does not apply to treatment by a provider or provider group whose contract with Brand New Day/Central Health Medicare Plan has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud, or other criminal activity.

**Transition of Care (TOC):**
Each year, new members will join Brand New Day/Central Health Medicare Plan who have been participating in other insurance carriers/plans. New members may need a period of Transition of Care, which allows the member to stay with their current providers and treatments until they can transition care to In- network providers, practices, or formulary medications.

- New members should apply for Transition of Care within 30 days from the time their Brand New Day/Central Health Medicare Plan coverage becomes effective.
- Requests will be reviewed within 10 days of receipt, except for organ transplant requests which will be reviewed within 30 days.
- If a new member is under the care of an out-of-network provider for one of the medical conditions below, Brand New Day/Central Health Medicare Plan may arrange, at the new member's request and subject to the Provider's agreement, for transition of Covered Health Services rendered by the out of network Provider for the time periods shown here:
    - *Acute Condition or Serious Chronic Condition* (see below for examples) that cannot be safely and effectively transferred to an in-network provider. Treatment by the out of network Provider may continue for up to 3 months.
        - For standard requests, approval will be made in one month increments up to three times.
        - Referrals will be made by the Utilization Management team to Brand New Day/Central Health Medicare Plan 's Care Management team to assist the member to transition to a contracted Brand New Day/Central Health Medicare Plan provider as appropriate.
    - *High-risk pregnancy* or a *pregnancy that has reached the second or third trimester.* Treatment by the out of network Provider may continue until the postpartum services related to the delivery are completed.

**Acute and Serious Chronic Condition Examples:**

- Acute illness (for example, heart attack, stroke, acute exacerbation of a chronic or disabling illness, recent major surgery, major trauma, facility admission (COC only).
- Staged surgical procedures that were already initiated.
- Terminal illness with survival of six months or less.
- Recently diagnosed cancer in the midst of treatment and/or reconstruction.
- Transplantation: recent candidacy, unstable recipient, complications in active treatment.
- Mental illness or substance use disorder undergoing active treatment (see active treatment period).
- High-risk pregnancy: age $\geq$ 35 years, premature delivery in previous pregnancy, gestational diabetes, pregnancy-induced hypertension/pre-eclampsia, multiple admission during current pregnancy, pregnancy complicated by a serious illness, other.

## BACKGROUND

### General Philosophy and Values

- Continuity of Care (COC) and Transitions of Care (TOC) should:
  - Be as safe, easy, and seamless as possible for Brand New Day/Central Health Medicare Plan members.
  - Not disrupt essential treatment of acute and serious health conditions that cannot otherwise be transferred to an in-network provider.
  - Be flexible to realize the values of the Brand New Day/Central Health Medicare Plan and the individual needs of the member.
- If COC or TOC coverage is approved, no changes in provider or facility will be required immediately. However, in-network alternatives will be identified and care transitioned within three (3) months of:
  - Membership coverage with Brand New Day/Central Health Medicare Plan for new members or
  - Upon notification of a provider network termination unless individual consideration for extension is needed.
- Approval of requests for COC and TOC are subject to clinical review of medical necessity, appropriateness and safety (for example, the reason for terminating a provider may be evaluated during the clinical review)
- Coverage for COC and TOC is limited to a specific out-of-network provider and/or out-of-network facility where the member has been receiving ongoing treatment. It excludes all other unrelated services which must be provided by in-network providers.
- Coverage for COC and TOC excludes routine services (exams, vaccinations, etc.), stable or controlled chronic conditions, acute minor illnesses, scheduled elective procedures (for example, stress test, x-rays and other imaging services, non-urgent procedures for varicose veins, lesion removal, hernia repair, etc.).
- Coverage for COC and TOC is not an authorization for additional services and is not a guarantee for payment to the provider for services subject to other applicable policies such as pre-certification or prior authorization, experimental treatment, etc.

### Regulatory Requirement on Provision of Continuity of Care

Brand New Day/Central Health Medicare Plan will adhere to all regulatory (state, federal and accreditation) guidelines and standards.

- **Federal Requirements:**
  - **Applicability:** Continuity of care coverage and notification of such is required when:
    - a provider/facility is terminated, and
    - the enrollee is considered a “continuing care patient” of that provider/facility
  - **Benefit Terms and Length of Coverage:** coverage must continue under the same terms and conditions for the shorter of:
    - 90 days from date of notification to the enrollee, or
    - The date on which the enrollee is no longer considered a continuing care

patient with respect to the terminated provider/facility

- **State Requirements:** For individual state requirements see the policy appendix

**Forms**
Refer to the Continuity of Care and Transition of Care form on the Brand New Day/Central Health Medicare Plan Utilization management website.

**DEFINITIONS**

1. **Active treatment** means regular visits to a practitioner for managing and monitoring the status of an illness or disorder that has not stabilized, providing direct treatment, prescribing medication or other treatment or modifying the treatment plan. For acute illness, defined as 3-4 weeks before enrollment or provider status change. For recent major surgery, 6-8 weeks post-surgery.
2. **Continuity of Care (COC)** means the process where **existing** plan members in active treatment with an In-Network (INN) provider whose contract with Bright is terminated (for reasons other than quality deficiencies) or who choose to leave the Network are evaluated and managed for ongoing care under the terms of their member benefits and network plan design generally for up to 3 months.
3. **Continuing Care Patient**[1]- The term 'continuing care patient' means an individual who, with respect to a provider or facility,
    a. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
    b. is undergoing a course of institutional or inpatient care from the provider or facility;
    c. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
    d. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
    e. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.
4. **Transition of Care (TOC)** means the process where **new** plan members, in active treatment by an Out of Network (OON) provider at the time their Brand New Day/Central Health Medicare Plan coverage becomes effective, are evaluated and managed for ongoing care under the terms of their member benefits and network plan design generally for up to 3 months.
5. **Carrier** means any entity that provides health coverage including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and regulations of the state involved.

6. **Claim** means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: 1) Services—including supplies; 2) Payment for all or a portion of the expenses incurred; 3) A combination of 1 and 2; or 4) An indemnification.
7. **Covered person or Member** means a person entitled to receive benefits or services under a health coverage plan and includes the designated representative of a member.
8. **Health care services** means any services included in the furnishing to any individual of medical, mental, dental, or optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human physical or mental illness or injury. "Health care services" includes the rendering of such services through the use of telemedicine.
9. **Network** means a group of participating providers providing services to a managed care plan. Any subdivision or subgrouping of a network is considered a network if covered individuals are restricted to the subdivision or subgrouping for covered benefits under the managed care plan.
10. **Participating provider** (or In-Network Provider) means a provider that, under a contract with a carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier.
11. **Provide**r means any physician, dentist, optometrist, anesthesiologist, hospital, imaging center, laboratory and ambulance services, or other person or entity that is licensed or otherwise authorized in the state to furnish health care services.
12. **Serious and Complex Condition[2]-** The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage
    a. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
    b. in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.
13. **Terminated Provider** or **Terminated[3]** means any practitioner or provider no longer a part of Brand New Day/Central Health Medicare Plan provider networks. This policy applies to providers whose contract with Brand New Day/Central Health Medicare Plan expired, was not renewed, or was terminated for reasons other than a medical disciplinary cause, fraud, or other criminal activity.
14. **Utilization management** means programs designed to assure appropriate utilization of health services relative to established standards or norms.

**CODING CPT CODES**
Not Applicable

**EVIDENCE BASED REFERENCES AND CITATIONS**
URAC HPHIX 59—P-OPS-6, Core 36

**EXHIBITS/ATTACHMENTS**

**APPENDIX A: STATE SPECIFIC REQUIREMENTS**

**I. Alabama**
Law is silent. Follow base policy.

**II. Arizona**
Law is silent. Follow base policy.

**III. California**
See Policy MED-087.CA California Continuity of Care

**IV. Colorado[4]**
Brand New Day/Central Health Medicare Plan will allow members who meet the continuing care criteria below to continue receiving care for up to 90 days after the date of notification to the member when:

- A participating provider or facility's contract has been terminated due to expiration or nonrenewal of the contract.
- The member's benefits with a provider or facility are terminated or expired Changes in the terms of the participation in the plan or coverage.

*Note: for the purposes of this section, "terminated" means the expiration or nonrenewal of the contract, except that "terminated" does not include a contract terminated for failure to meet quality standards or for fraud.*

The member's coverage must be provided at the in-network benefit level cost-sharing amount from the date of the notice of termination and ending on the earlier of:

- 90 days after the date of notification.
- The member is no longer a continuing care patient with the impacted provider or facility.

Continuing care patients include members who re undergoing a course of treatment with the terminated provider, including treatment for the following:

- Treatment serious or complex medical condition
  - Acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
  - Chronic illness, a condition that is life-threatening, degenerative, potentially disability, or congenital and requires specialized medical care over a prolonged period of time
- Episode of inpatient care

- Pregnancy
- Terminal Illness (as determined by 1861 (dd)(3)(A) of the federal "Social Security Act", as amended, and is receiving treatment for the illness
- Scheduled non-elective surgery, including postoperative care

## V. Florida[5]

When a contract between Brand New Day/Central Health Medicare Plan and a treating provider is terminated for any reason other than for cause, each party will allow members for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the member was receiving care at the time of the termination, until the member selects another treating provider, or during the next open enrollment period offered by Brand New Day/Central Health Medicare Plan , whichever is longer, but not longer than 6 months after termination of the contract. Each party to the terminated contract will allow a member who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care

For care continued under this subsection, Brand New Day/Central Health Medicare Plan and the provider will continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

## VI. Georgia[6]

*Continued Coverage - Reliance on Electronic Directories*

If a provider is listed in the electronic provider directory when an enrollee selects coverage during the open enrollment period, and is later terminated, Brand New Day/Central Health Medicare Plan Care must continue to reimburse the provider at the most recent contracted rate, for the sooner of:

- 180 days from termination, or
- The last day of coverage

*Exceptions*

Continued coverage due to reliance on an electronic directory is not required if:

1. Provider's license is suspended, expired, or revoked.
2. Provider unilaterally terminates without cause.
3. Insurer terminates provider for fraud, misrepresentation, or other actions constituting a termination for cause, or
4. The electronic provider directory accurately displayed the future date that the provider would be considered out-of-network 15 days prior to, and all during the open enrollment time frame.

## VII. Illinois[7]

Brand New Day/Central Health Medicare Plan will provide to members a description of the provisions for continuity of treatment in the event a health care provider's participation terminates during the course of a member's treatment by that provider.

## VIII. Nebraska[8]

Brand New Day/Central Health Medicare Plan ’s access plan will include a proposed plan for providing continuity of care in the event of contract termination between Brand New Day/Central Health Medicare Plan and any of its participating providers. The description will explain how members will be notified of the contract termination or Brand New Day/Central Health Medicare Plan ’s insolvency or other cessation of operations and transferred to other providers in a timely manner.

## IX. North Carolina[9]

If a contract between Brand New Day/Central Health Medicare Plan and a health care provider is terminated by the provider or by Brand New Day/Central Health Medicare Plan and a member covered by the plan is undergoing treatment from the provider for an ongoing special condition on the date of the termination, then, Brand New Day/Central Health Medicare Plan will permit the member to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period. An exception to this is when Brand New Day/Central Health Medicare Plan terminates a provider's contract for reasons relating to quality of care or fraud. The transitional period shall extend up to 90 days, as determined by the treating health care provider, after the date of the notice to the member.

If a member was determined to be terminally ill at the time of a provider's termination, and the provider was treating the terminal illness before the date of the termination, the transitional period will extend for the remainder of the member's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

Brand New Day/Central Health Medicare Plan may condition coverage of continued treatment by a provider upon the provider agreeing to:

- Accept reimbursement from Brand New Day/Central Health Medicare Plan and the member involved, with respect to cost-sharing, at the rates applicable before the start of the transitional period as payment in full
- Comply with the quality assurance programs of Brand New Day/Central Health Medicare Plan and to provide Brand New Day/Central Health Medicare Plan with the necessary medical information related to the care provided
- Adhere to Brand New Day/Central Health Medicare Plan 's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan, if any, approved by Brand New Day/Central Health Medicare Plan, and member hold harmless provisions; and
- Discontinue providing services at the end of the transition period pursuant to this section and to assist the member in an orderly transition to a network provider.

## X. Oklahoma[10]

Termination: Brand New Day/Central Health Medicare Plan will establish procedures governing termination of a participating provider who is terminated for reasons other than cause. The procedures will include assurance of continued coverage of services, at the

contract terms and price by a terminated provider for up to 90 calendar days from the date of notice to the member who:

- Has a degenerative and disabling condition or disease; or
- Is terminally ill.

Disaffiliation: If a participating provider voluntarily chooses to discontinue participation as a network provider in a plan, Brand New Day/Central Health Medicare Plan will permit a member to continue an ongoing course of treatment with the disaffiliated provider during a transitional period of up to 90 days from the date of notice to Brand New Day/Central Health Medicare Plan of the provider's disaffiliation from Brand New Day/Central Health Medicare Plan 's network.

Continuing care will be authorized by Brand New Day/Central Health Medicare Plan during the transitional period only if the disaffiliated provider agrees to:

- Continue to accept reimbursement from Brand New Day/Central Health Medicare Plan at the rates applicable prior to the start of the transitional period's payment in full;
- Adhere to Brand New Day/Central Health Medicare Plan 's quality assurance requirements and to provide to Brand New Day/Central Health Medicare Plan necessary medical information related to such care; and
- Otherwise adhere to Brand New Day/Central Health Medicare Plan 's policies and procedures, including, but not limited to, policies and procedures regarding references, and obtaining preauthorization and treatment plan approval from Brand New Day/Central Health Medicare Plan.

## XI. South Carolina[11]

Continuation of care must be provided for 90 days or until the termination of the benefit period, whichever is greater.

If a provider contract is terminated or nonrenewed, Brand New Day/Central Health Medicare Plan and the provider will comply with the following requirements except in the case of suspension or revocation of the provider's license:

- Brand New Day/Central Health Medicare Plan is liable for covered benefits rendered in the continuation of care by a provider to a member for a serious medical condition. The benefits payable for services rendered during the continuation of care are subject to the policy's or contract's regular benefit limits.
- Brand New Day/Central Health Medicare Plan will not require a member to pay a deductible or copayment which is greater than the in-network rate for services rendered during the continuation of care.
- Brand New Day/Central Health Medicare Plan will not require a member, as a condition of continued coverage under the plan, to pay a premium or contribution which is greater than the premium or contribution for a similarly situated member on the basis of covered benefits rendered as provided for in this section to the member or the dependent of a member.
- The provider shall accept as payment in full for services rendered within in the continuation of care the negotiated rate under the provider contract.

- Except for an applicable deductible or a copayment, a provider will not bill or otherwise hold a member financially responsible for services rendered in the continuation of care and furnished by the provider, unless the provider has not received payment in accordance with item (4) of this subsection and in accordance with Article 2, Chapter 59 of this title.
- Brand New Day/Central Health Medicare Plan is responsible for determining if a member qualifies for continuation of care and may request additional information in reaching such determination.

## XII. Tennessee[12]

If a provider terminates its agreement with Brand New Day/Central Health Medicare Plan , or Brand New Day/Central Health Medicare Plan terminates the provider without cause, then the provider and Brand New Day/Central Health Medicare Plan will allow a member who is under active treatment for a particular injury or sickness, to continue to receive covered benefits from the treating provider for the injury or sickness for a period of 120 days from the date of notice of termination if the treating provider agrees to continue to be bound by the terms, conditions, and reimbursement rates of the provider's agreement with Brand New Day/Central Health Medicare Plan .

## XIII. Texas[13]

A contract between Brand New Day/Central Health Medicare Plan and a provider must provide that termination of the contract does not release Brand New Day/Central Health Medicare Plan from the obligation of continuing to reimburse a provider providing medically necessary treatment at the time of termination to a member who has a special circumstance in accordance with the dictates of medical prudence. The treating provider will identify a special circumstance. An exception to this is if a provider was terminated for reason of medical competence or professional behavior.

- In this section, "special circumstance" means a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to a member. Examples of a member who has a special circumstance include a member with a disability, acute condition, life-threatening illness, or who is past the 24th week of pregnancy.

Brand New Day/Central Health Medicare Plan must provide continued reimbursement at not less than the contract rate in exchange for the member's continued receipt of ongoing treatment from the provider until:

- The 90th day after the effective date of the termination;
- The expiration of the nine-month period after the effective date of the termination if the member has been diagnosed with a terminal illness at the time of termination; or
- For members past the 24th week of pregnancy, through delivery of the child and immediate postpartum care and a follow-up checkup(s) within the six-week period after delivery.

The treating provider must:

- Request that a member be permitted to continue treatment under the provider's care; and

- Agree not to seek payment from the member of any amount for which the member would not be responsible if the provider continued to be included in the Brand New Day/Central Health Medicare Plan network.

A contract between Brand New Day/Central Health Medicare Plan and a provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a provider.

## XIV. Utah

Law is silent. Follow base policy.

## XV. Virginia[14]

For a period of at least 90 days from the date of the notice of a provider's termination from Brand New Day/Central Health Medicare Plan 's provider panel, except when a provider is terminated for cause, the provider will be permitted by Brand New Day/Central Health Medicare Plan to render health care services to any Brand New Day/Central Health Medicare Plan members who:

- Were in an active course of treatment from the provider prior to the notice of termination; and
- Requested to continue receiving health care services from the provider.

However, if the member is terminally ill and the provider is providing treatment directed at the terminal illness, then the provider can continue to provide care for the remainder of the member's life unless the termination was for cause.

Brand New Day/Central Health Medicare Plan will reimburse a provider under this subsection in accordance with Brand New Day/Central Health Medicare Plan 's agreement with such provider existing immediately before the provider's termination of participation.

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[1] PHS Title XXVII 42 U.S.C. 300gg (sec) 2799A-3
[2] PHS Title XXVII 42 U.S.C. 300gg (sec) 2799A-3
[3] PHS Title XXVII 42 U.S.C. 300gg (sec) 2799A-3
[4] 3 CCR 702-4(Series 4-2-56); C.R.S. 25-37-111; C.R.S. 10-16-705(4)
[5] Fla. Stat. § 641.51(8)]
[6] GA HB454 / GA Code § 33-20C-3
[7] 215 ILCS 134/15(a)(8)]
[8] R.R.S. Neb. § 44-7105(i)
[9] N.C. Gen. Stat. § 58-67-88 (b)]
[10] 63 Okl. St. § 2550.3
[11] S.C. Code Ann. § 38-71-243
[12] Tenn. Code Ann. § 56-7-2358
[13] Tex. Ins. Code § 843.362 & 28 TAC §11.901(b)(2)
[14] Va. Code Ann. Section 38.2-3407.10 (F)

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**POLICY HISTORY**

**Medical Policy**

Approved by the Utilization Management Committee 8/2022

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| Original Effective Date | September 30, 2019 |
| Revised Date | December 5, 2019 – Add MA as applicable product<br>December 17, 2020 – Annual review; new language defining approvals in one-month increments, added small group<br>December 30, 2021 – Annual review; removed CA from scope, added reference to COC/TOC form<br>May 5, 2022 – Included federal and state regulatory requirements<br>August 18, 2022 – updated CO requirements section<br>March 1, 2023 - Adopted by MA UM Committee (no policy revisions made)<br>January 1, 2024 - Updated to Brand New Day/Central Health Medicare Plan/Central Health Medicare Plan |