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## **17. MEMBER TRANSFERS AND DISENROLLMENT**

- A. Primary Care Physician (PCP) Transfers
    - 1. Voluntary
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### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

### **POLICY:**

- A. IEHP makes best efforts to accommodate Member requests for transfer of PCPs whenever possible.
- B. IEHP's goal is to respond to Member needs, facilitate continuity of care, and retain IEHP Membership.
- C. IEHP Members can change PCPs on a monthly basis.

### **PROCEDURE:**

- A. A Member may request to transfer to another PCP by calling an IEHP Member Services Representative (MSR) at (800) 440-4347.
- B. If the request to change a PCP is received by the 25th of the month, IEHP changes the Member's PCP effective the first day of the following month. If IEHP receives the Member's request after the 25th of the month, the change is effective the first day of the second month following the request, unless otherwise approved.
- C. If the Member is hospitalized, confined in a Skilled Nursing Facility (SNF), or receiving other acute institutional care at the time of request, the change is effective the first day of the next month following the Member's discharge from the facility.
- D. A Member's request for transferring to another PCP may be denied by IEHP for the following reasons:
  - 1. The requested PCP is closed to new enrollees due to capacity limitations.
  - 2. The requested PCP is no longer credentialed or contracted with an IEHP affiliated IPA.
  - 3. The Member does not reside within 10 miles or 30 minutes of the requested PCP, unless otherwise approved.
  - 4. The IEHP Chief Medical Officer or Medical Director determines the transfer would have an adverse effect on the Member's quality of care.
- E. IEHP must notify Members of any termination by the Member's PCP or IPA 30 days in advance of the inability to provide services. In this event, the Member may continue to receive care from the PCP until IEHP has made provisions for the assumption of health care services by another PCP and notified the Member by phone or mail.

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## 17. MEMBER TRANSFERS AND DISENROLLMENT

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### A. Primary Care Physician (PCP) Transfers

#### 1. Voluntary

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- F. Under specific circumstances, Member transfers may be retroactive.
1. Retroactive PCP transfers for Members that have been enrolled with IEHP for 10 days or less, can occur if all of the following are met:
    - a. The newly enrolled Member, the Member's parent, or legal guardian contacts Member Services by the 10<sup>th</sup> of their first month of enrollment.
    - b. The Member has not accessed any medical services (e.g., E.D. visit, PCP visit, etc.).
  2. Retroactive PCP transfers for Members that have been enrolled with IEHP for greater than 10 days can occur under the following circumstances:
    - a. Members assigned to a PCP greater than 10 miles or 30 minutes from their home, or assigned to a Hospital greater than 15 miles or 30 minutes from their home; or Members assigned to an inappropriate PCP specialty type (e.g., adult assigned to a pediatrician); or Members assigned to a PCP different than other family Members (assuming appropriate specialty of PCP).
    - b. For all of the above, the Member must not have chosen the PCP, and must not have accessed services during the current month.
    - c. The request for a retroactive transfer is made by the Member, the Member's parent, or legal guardian.
  3. Other retroactive PCP transfers can occur due to continuity of care or other circumstances as approved by the Director of Provider Services, IEHP Chief Medical Officer, or designees.
- G. If a Provider notifies IEHP that a Member is assigned to a PCP greater than 10 miles or 30 minutes from the Member's residence, to a Hospital more than 15 miles or 30 minutes from the Member's residence, to the wrong specialty type, or that family members are split between PCPs, IEHP researches how the Member was assigned to the PCP.
1. If the Member did not choose the PCP, a written notice is sent to the Member notifying the Member that reassignment to an appropriate PCP will occur within 30 days (or more), unless the Member contacts IEHP.

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## 17. MEMBER TRANSFERS AND DISENROLLMENT

- A. Primary Care Physician (PCP) Transfers
    - 2. Involuntary
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### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

### **POLICY:**

- A. Involuntary PCP transfers can occur upon request by the PCP, after specific criteria are met and approved by the IPA Medical Director and IEHP Chief Medical Officer.
- B. In cases when an involuntary PCP transfer for a Member has occurred two times in a consecutive 12-month period, the IPA Medical Director may contact IEHP to request transfer of the Member to another IPA.
- C. If that same Member has two or more involuntary PCP changes in the new IPA within a six-month period, then a request for involuntary disenrollment from IEHP is made to DHCS, in accordance with Policy 17B3, “Disenrollment from IEHP, Involuntary - Member Behavior.”
- D. Except as defined below, Member PCP transfers are a voluntary process performed at the request of the Member, within timeframes and processes as noted in Policy 17A1, “Primary Care Physician (PCP) Transfers – Voluntary.”

### **PROCEDURE:**

- A. Involuntary PCP transfers can be requested by a PCP due to a breakdown of the physician-Member relationship and the inability of the PCP to continue providing care to the Member. The PCP must make his/her request in writing to the IPA Medical Director and include at a minimum the following information:
  - 1. Name and identification number of Member
  - 2. Length of PCP-Member ongoing care relationship
  - 3. Reason for request of involuntary PCP change
- B. The IPA Medical Director, in conjunction with IPA Case Management (CM), is responsible for assessing the PCP-Member relationship and/or the eligibility and medical status of the Member that has resulted in the request for involuntary PCP change. IEHP CM is available for consultation at any time during the process.
- C. All efforts are made by the IPA to preserve PCP-Member relationships to ensure continuity of care.
- D. In cases where it appears that the PCP-Member relationship has deteriorated to the point that the IPA believes a PCP transfer is necessary, IPA staff must work directly with the Member to coordinate a voluntary PCP transfer within the IPA. The Member would then

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call IEHP Member Services and request the voluntary PCP transfer. IEHP CM is available to have joint meetings or telephone conferences with the Member and IPA as needed.

- E. If the IPA Medical Director determines after the assessment that the PCP-Member relationship has deteriorated to the point that it impacts or potentially impacts the care of the Member, and the Member is unwilling to voluntarily change PCPs, the IPA Medical Director must notify the IEHP Chief Medical Officer in writing. The written description must include:
1. The name and identification number of the Member
  2. Reasons for request of involuntary PCP change
  3. Plan for assuring Member continuity of care
- F. The plan for assuring Member continuity of care must include options for the new PCP assignment and transfer of care. The IPA has two options:
1. Recommend assigning the Member to another PCP within the IPA with subsequent transfer of care facilitated by the IPA.
  2. Refer the Member to IEHP CM for new PCP assignment and transfer of care.
- G. The IEHP Chief Medical Officer reviews the request, obtains additional information from the IPA, the Member, the PCP and IEHP staff as needed, and then approves or denies the request.
- H. If the request for transfer is approved, IEHP informs the IPA and the Member regarding the transfer, including specifics of the new PCP and timeframes for the transfer.
- I. The IPA remains responsible for any care required by the Member until the PCP transfer is completed.
- J. The Peer Review Subcommittee serves as the review body for any disagreements between the PCP, Member, IPA and/or IEHP regarding involuntary PCP changes.
- K. IEHP monitors involuntary PCP transfers for Members within an IPA. In cases when an involuntary PCP transfer for a Member has occurred two times in a consecutive 12-month period, the IPA Medical Director may contact IEHP to request transfer of the Member to another IPA.
- L. If that same Member has two more involuntary PCP changes in the new IPA within a six-month period, then a request for involuntary disenrollment from IEHP is made to DHCS, in accordance with Policy 17B3, "Disenrollment From IEHP, Involuntary - Member Behavior."

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## 17. MEMBER TRANSFERS AND DISENROLLMENT

### B. Disenrollment From IEHP

#### 1. Voluntary

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

- A. A Member may disenroll from IEHP at any time, for any reason, by submitting their signed request for disenrollment (letter or form) to Health Care Options (HCO).
- B. IEHP is responsible for attempting to resolve any problems and educate the Member on how IEHP works in an effort to retain the Member. However, IEHP does not interfere with a Member's request to disenroll.
- C. Final disenrollment decisions are handled entirely by The Department of Health Care Services' (DHCS).

#### **PROCEDURE:**

- A. Disenrollment forms are only available through HCO locations or IEHP can mail a disenrollment form to a Member (Choice form). Physician offices may not make copies of the disenrollment form.
- B. Requests for disenrollment through IEHP Member Services are handled in the following manner:
1. IEHP explains that the Member may disenroll and requests information concerning the reason for disenrollment to track and trend for quality issues. The Member is not required to provide any justification. However, if reasons are provided IEHP may be able to resolve the situation by explaining how membership with IEHP works, facilitating appointments, resolving service issues, among others.
  2. IEHP explains how a disenrollment form may be obtained and how the disenrollment process works, as follows:
    - a. IEHP provides the phone number and/or address/directions to the HCO office.
    - b. Upon request mails a disenrollment form to the Member.
    - c. The Member must send either a letter or a disenrollment form to HCO.
    - d. Disenrollment does not become effective for 15 to 45 days, depending on when the notification is given to HCO by the Member, until that time the Member remains active in IEHP.

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#### 1. Voluntary

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3. IEHP documents the call in the Customer Service System identifying the following:
    - a. The name and ID number of the Member;
    - b. The reason for the call;
    - c. Any attempt made to resolve any issues; and
    - d. The resolution of the call.
- C. Final disenrollment decisions are handled entirely by DHCS.

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## 17. MEMBER TRANSFERS AND DISENROLLMENT

### B. Disenrollment From IEHP

#### 2. Involuntary - Member Status Changes

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##### **APPLIES TO:**

- A. This policy applies to IEHP Medi-Cal Members only.

##### **POLICY:**

- A. IEHP reserves the right to request involuntary disenrollment of Members under specific guidelines set forth by The Department of Health Care Services' (DHCS).
- B. IEHP Providers may, under specific circumstances, request that IEHP review a given Member situation for possible disenrollment consideration.
- C. Final disenrollment decisions are handled entirely by DHCS.

##### **PROCEDURES:**

- A. Members requesting disenrollment or information about disenrollment must be immediately referred to IEHP Members Services in accordance with Policy 17B1, "Disenrollment from IEHP – Voluntary."
- B. Members are no longer eligible for enrollment with IEHP and are involuntarily disenrolled from IEHP if the Member:
1. Moves out of the IEHP geographic service area as determined by DHCS.
  2. No longer qualifies for Medi-Cal benefits as determined by DHCS.
  3. Has changed to a Medi-Cal Aid Code which is not covered under IEHP.
  4. Has become incarcerated.
  5. Is a child in the Foster Care system and moves outside the geographic service area.
- C. Providers that become aware of one of the above situations should direct the Member to contact IEHP Member Services at (800) 440-4347.
- D. If a Member meets any of the above criteria, it is the responsibility of IEHP to notify DHCS to disenroll these Members from IEHP.
- E. The majority of involuntary disenrollments are initiated by the Member's Medi-Cal eligibility worker.

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- F. In certain circumstances, the PCP and/or IPA may initiate a request to disenroll the Member, in accordance with Policy 17B3, “Disenrollment from IEHP – Involuntary - Member Behavior.”
- G. If IEHP determines that disenrollment of the Member is the best course of action under the circumstances:
1. The Member is notified in writing by IEHP of the intent to disenroll 20 days in advance of the request to DHCS, and the Member is allowed to respond to the proposed action by contacting IEHP Member Services.
  2. The written response from the Member must be received prior to the date IEHP sends notice to DHCS.
  3. IEHP reviews any appeal information from the Member and then determines whether to continue with the request for involuntary disenrollment.
  4. IEHP submits a written request for involuntary disenrollment to DHCS with all necessary supporting documentation, including appeal information from the Member, if applicable.
  5. DHCS has 10 working days to respond to the request.
  6. The PCP and IPA must continue rendering services to the Member until IEHP notifies the IPA that DHCS has disenrolled the Member.
- H. Final approval and the determination of the effective date for involuntary disenrollment is made by DHCS.

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## 17. MEMBER TRANSFERS AND DISENROLLMENT

### C. Loss of Medi-Cal Eligibility - PCP Responsibilities

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#### APPLIES TO:

- A. This policy applies to all IEHP Medi-Cal Members only.

#### POLICY:

- A. PCPs inform Members who have lost Medi-Cal eligibility of the availability of other services, and make referrals for continuation of care.

#### PROCEDURE:

- A. IEHP provides IPAs with information about alternate sources of care, including brochures and access numbers.
- B. PCPs should assist Members in accessing these other available services by providing the access numbers, and facilitating transfer of medical records, as appropriate.
- C. Referrals must be documented in the Member's medical record.
- D. If the Member is a child, and the PCP is an approved Child Health and Disabilities Program (CHDP) practitioner, the PCP may continue to provide care through the CHDP 200% program if the family meets the income criteria.
- E. If the Member is a child and the PCP is not an approved CHDP practitioner, the PCP should refer the Member to the Local Health Department (LHD), to be referred to a certified CHDP practitioner.
- F. If the Member is pregnant, and the obstetrical (OB) practitioner is an approved Comprehensive Perinatal Services Program (CPSP) practitioner, the practitioner may continue to provide care through the fee-for-service CPSP program.
- G. If the Member is pregnant, and the OB practitioner does not accept Medi-Cal fee-for-service, the practitioner should refer the Member to the LHD, to be referred to a certified CPSP practitioner.
- H. Non-pregnant adults should be referred to the Medically Indigent Services programs of both LHDs, for further screening and eligibility determination.
- I. IEHP Member Services is available to assist the Member or PCP in accessing resources.

#### Referral Numbers:

1. IEHP Member Services: (800) 440-4347
2. LHD - Riverside County
  - Perinatal Services (800) 794-4814
  - Children's Services (951) 358-5401

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### C. Loss of Medi-Cal Eligibility - PCP Responsibilities

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- Medically Indigent Services Program (951) 486-5375
- 3. LHD-San Bernardino County
  - Perinatal Services (800) 227-3034
  - Children's Services (909) 387-8400
  - Medically Indigent Adult Health Care (909) 580-1077
- 4. Healthy Families: (800) 440-4347
- 5. CHDP
  - Riverside County (951) 358-5481  
1-800-346-6520
  - San Bernardino County (909) 387-6499  
1-800-722-3777

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## 17. MEMBER TRANSFERS AND DISENROLLMENT

### D. Continuity of Care

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

A. Definitions:

1. “Provider” means any IPA, Medical Group, or acute care hospital; “provider” – means any professional person, organization, health facility, acute care hospital or other person or institution licensed by the State to deliver or furnish health services.
2. “Non-contracted provider” – means any provider that is not contracted with IEHP.
3. “Terminating provider” – means a provider whose contract with IEHP is in the process of termination, regardless of which entity initiated the termination process.

B. Current and Newly Enrolled Members

1. Upon their request, current IEHP Members or newly enrolled Members with specified conditions may continue to obtain health care services from a terminated or non-contracted provider for a specific time frame as noted below:
  - a. 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.
  - b. 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 IEHP in consultation with the Member and the terminated provider or non-contracted provider, consistent with good professional practice. 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 Member.
  - c. For Members in the 2<sup>nd</sup> and 3<sup>rd</sup> trimesters of pregnancy and the immediate postpartum period, services shall be covered for the duration of the pregnancy and the immediate postpartum period.

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### D. Continuity of Care

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- d. 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 the terminal illness.
  - e. Newborn childcare is 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 Member.
  - f. Authorized surgery or other procedure is a medical procedure that is authorized by IEHP, if you are a current Member, or by a previous plan, if you are a new Member, as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the effective date of coverage for a newly enrolled Member, or within 180 days of the termination of the provider for a current Member.
2. The terminated or non-contracted provider in general must agree to terms and conditions and rates consistent with those used by the Plan or provider group in the same or similar geographic area.
  3. This policy is not applicable for current Members if the provider was terminated for medical disciplinary cause, fraud or other criminal activity, or newly covered enrollees with individual coverage.
- C. All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy, and upon request, IEHP must send a copy of the policy to a Member.
- D. For newly enrolled SPD beneficiaries who request continued access to a provider with whom they have an ongoing relationship, IEHP or IPA shall provide continued access for up to 12 months even if the provider is an out-of-network provider. IEHP or IPA must ensure there are no quality of care issues with the provider, and that the provider will accept IEHP/IPA or Medi-Cal FFS rates, whichever is higher, in accordance with W & I Code 14182(b)(13) and (14).
- E. If a Member continues care with a terminated or non-contracted provider, the financial responsibility for the care is determined by the financial responsibility matrix within the applicable IEHP Agreement. IEHP will ensure that any applicable co-payments will remain the same.
- F. In the case of current Members and a terminated provider, Members are notified in writing of the termination and their right to continue care 60 days prior to the termination effective date.
- G. In the case of a block transfer of Members from a provider group or general acute care hospital, Members are notified in writing at least 60 days prior to the termination. All assigned Members who reside within a 15-mile radius of the terminating hospital are

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notified in writing.

- H. IEHP reserves the right to make final decisions regarding continuity of care. An IEHP Medical Director makes such decisions with consideration given to the potential effects on the Member's clinical condition and treatment.
- I. Members can request assistance or ask questions about continuity of care by calling IEHP Member Services.
- J. IEHP is not required to cover services that are not otherwise covered by the Plan.

#### **PROCEDURE:**

##### A. Newly Enrolled Members

1. All newly enrolled Members receive the IEHP's notice of the continuity of care policy in the Member Handbook that is sent at time of enrollment.
2. Any newly enrolled Member may obtain a copy of this policy upon written request to IEHP or by calling Member Services at (800) 440-4347.
3. Any newly enrolled Member requesting to continue their care with a non-contracted provider must be referred to IEHP Member Services.
  - a. Any such request to IEHP Member Services is referred to the appropriate IEHP Care Manager with subsequent referral to an IEHP Medical Director, if necessary.
  - b. An IEHP Medical Director will review the request within 72 hours for urgent matters and issue a response within that timeframe. For an acute condition, the matter will be reviewed and responded to within 5 days. For non-urgent matters, the matter will be reviewed and responded to within 10 days.
4. If a newly enrolled Member currently under the care of a non-contracted provider has a condition that meets the criteria noted in the policy section, they can continue care with that provider for a time period consistent with regulatory requirements and their clinical condition.
5. Financial responsibility for costs associated with the non-contracted provider is based on the IEHP financial responsibility matrix within the applicable IEHP Agreement. IEHP will ensure that any applicable co-payments remain the same.
6. If a non-contracted provider refuses to accept terms and conditions consistent with those for similar providers in a similar geographic area, the IPA can request that IEHP deny the Member's request. Final decisions rest with the IEHP Chief Medical Officer.

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7. Unless otherwise agreed upon by the non-contracted provider and IEHP or by the non-contracted provider and the provider group, the continuity of care services rendered under this Policy will be compensated at rates and methods of payment similar to those used by IEHP or the provider group for currently contracted providers providing similar services who are not capitated and who are practicing in the same geographic area as the non-contracted provider.

### B. Current Members

1. Current Members who have a condition that meets the criteria delineated herein may qualify to continue care with a terminated provider, except if the provider is terminated for medical disciplinary cause, fraud, or other criminal activity.
2. IEHP's Chief Medical Officer is responsible for determining a Member's review and arranging for current enrollee's continuity of care requests. Members currently under the care of an individual provider, who is being terminated, must be notified in writing by the IPA a minimum of 60 days in advance of the termination. "Under care" is defined as Members who have seen the provider two or more times in the preceding 12 month period, who are currently under on-going care, who have an open referral, or who are assigned to a PCP who is being terminated. IEHP reserves the right to make final decisions regarding continuity of care. An IEHP Medical Director makes such decisions with consideration given to the potential effects on the Member's clinical condition and treatment. Any such request to IEHP Member Services is referred to the appropriate IEHP Care Manager with subsequent referral to an IEHP Medical Director. A Medical Director will review and respond to urgent requests within 72 hours. For an acute condition, the matter will be reviewed and responded to within 5 days. For non-urgent matters, the matter will be reviewed and responded to within 10 days.
3. Any written, printed, or electronic notification to the Member regarding a contract termination or block transfer must include the following language in not less than 8-point font: *"If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov)."*
4. If a terminated provider refuses to accept terms and conditions consistent with those that were imposed prior to the contract termination date, the IPA can request that IEHP deny the Member's request. Final decisions rest with the IEHP Chief Medical Officer.

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5. Unless otherwise agreed upon by the terminated provider and IEHP or by the terminated provider and the provider group, the continuity of care services rendered under this Policy will be compensated at rates and methods of payment similar to those used by IEHP or the provider group for currently contracted providers providing similar services who are not capitated and who are practicing in the same or similar geographic area as the terminated provider.

### C. Block Transfers - In the event of the termination of a Provider contract that could involve the block transfer of Members, IEHP will do the following:

1. Notify and file with the Department of Managed Health Care (DMHC) at least 75 days prior to contract termination. In exigent circumstances, IEHP will apply for a waiver from DMHC regarding the 75-day filing and the 60-day notice to the Member requirement.
2. Provide all assigned Members with a written notice 60 days in advance of the contract termination, including language regarding their rights for continuity of care with existing providers as in B.3 above. In the case of a hospital termination, all assigned Members who reside within a 15-mile radius of the hospital, will be sent a written notice regarding the termination of the hospital contractual relationship.
3. If, after sending the required notice to Members, IEHP reaches an agreement with the Provider to enter into a new contract or to not terminate their contract, IEHP offers affected Members the option to return to their original provider. If the Member does not exercise this option, IEHP will reassign the Member to another provider.
4. If IEHP re-contracts with the terminating Provider within 90 days, IEHP will notify the assigned Members within 30 days in writing. IEHP will specify information in the notice for the Member to request a change back to their original provider by calling IEHP Member Services (1-800-440-4347).
5. Ensure continuity of care for Members meeting criteria specified in Section A of this policy.
6. If a Member submits a request for completion of covered services by a terminated or non-contracted provider, final decision is made by IEHP's Chief Medical Officer. Reasonable consideration will be given to the potential effect on a Member's treatment, caused by a change of *provider*. An IEHP Medical Director has 72 hours to respond to urgent requests and 10 days to respond to non-urgent requests in writing. For an acute condition, the matter will be reviewed within 5 days.
7. Re-assign all block transferred Members within DMHC's geographic access standards, as applicable.

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8. Assess the receiving Provider's administrative and financial capacity to accept and maintain the block transfer.
  9. The Provider Services Department, in cooperation with the Operations Department at IEHP, is responsible for the notification and re-assignment of Members.
  10. In the case of a contract termination with a hospital, IEHP will verify that there is an alternate hospital located within DMHC's geographic access standard for all assigned Members.
  11. Ensure that Members have the same range of services that are within DMHC's same standards of care.
  12. Ensure appropriate admitting arrangements.
- D. Financial responsibility for costs associated with the terminated provider is based on the IEHP financial responsibility matrix within the applicable IEHP Agreement. IEHP ensures that any applicable co-payments remain the same.
- E. IEHP reserves the right to make all final decisions regarding continuity of care for IEHP Members.
- F. Members may contact IEHP Member Services at (800) 440-4347 for assistance in selecting a new provider or to request continuity of care.

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## **17. MEMBER TRANSFERS AND DISENROLLMENT**

### **E. Episode of Care - Inpatient**

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#### **APPLIES TO:**

- A. This policy applies to all IEHP Medi-Cal Members.

#### **POLICY:**

- A. Members may be enrolled into IEHP or change Providers while hospitalized due to the enrollment process, Member requests, PCPs changing Provider affiliations, IPAs changing Hospital links, or contracts changing from a Capitated to a Per Diem fee schedule.
- B. IEHP has adopted the following procedures to minimize disruption of care for the Member while inpatient, as well as the financial impact to the new Provider.

#### **PROCEDURE:**

- A. Medi-Cal Fee-For-Service (FFS) Transition
1. When a FFS Medi-Cal recipient is admitted to the hospital, the Department of Health Care Services (DHCS) authorizes a length of stay by issuing a Treatment Authorization Request (TAR).
  2. If a FFS Medi-Cal recipient is assigned to IEHP while hospitalized, reimbursement for authorized services rendered, both professional and facility components, is the financial responsibility of DHCS for each day the TAR covers prior to the date of enrollment into IEHP.
  3. From the date of enrollment into IEHP until the date of discharge, the Capitated Financial Responsibility Matrix located in the IEHP Agreement defines payment responsibility. Capitation is paid to the assigned IPA and Hospital beginning the first of the month the Member is effective.
  4. The IPA must be involved in the care management and discharge planning of the Member.
- B. Member No Longer Eligible With IEHP
1. If a Member loses eligibility during an inpatient stay, IEHP and/or the IPA/Hospital is no longer financially responsible for services rendered as of the effective date of the Member's ineligibility.
  2. If a Medi-Cal Member is disenrolled from IEHP and remains Medi-Cal eligible, IEHP and/or the IPA/Hospital have no financial responsibility as of the effective date of the Member's disenrollment.

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## 17. MEMBER TRANSFERS AND DISENROLLMENT

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### E. Episode of Care - Inpatient

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#### C. Member Requested PCP Change

1. If a Member requests a PCP change prior to being hospitalized (e.g. Member calls on May 5<sup>th</sup> requesting a PCP change effective June 1 and was admitted and confined to the hospital since May 28), the previous IPA and Hospital or IEHP, as applicable, are responsible for the authorization and payment of all services provided until the Member is discharged from the hospital. Capitation is paid to the current IPA and Hospital, or IEHP as applicable, of the assigned PCP beginning the first of the month the Member change is effective. The previous and receiving IPA or IEHP should coordinate the care management, as applicable, of this Member to ensure appropriate discharge planning.

#### D. PCP Requested Hospital Change

1. When a PCP transfers affiliation from one IPA to another or from one Hospital to another, the receiving IPA/Hospital agrees to accept all Members, regardless of their medical condition.
2. The new IPA and Hospital, or IEHP, as applicable, are responsible for the authorization and payment for all services provided for any Members currently receiving inpatient care at the time of the transfer.
3. Capitation is paid to the new IPA and Hospital, as applicable, beginning the first of the month the PCP transfer is effective.

#### E. IPA Change Hospital Link

1. When an IPA transfers all PCP affiliations from a Hospital to another Hospital link, the previous Hospital, or IEHP, as applicable, is financially responsible for any Member receiving inpatient care until transfer or discharge.
2. Capitation is paid to the new Hospital, or IEHP, as applicable, the first of the month the new Hospital link is effective.

#### F. Capitated Hospital Changes to Per Diem

1. When a Hospital converts from a Capitated Agreement to a Per Diem Agreement with IEHP, payment for medical services for Members currently receiving inpatient care at the time of the transfer is covered under the capitation payment paid in the month the Members were admitted, until discharged.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Effective date:</b>	September 1, 1996
<b>Chief Title:</b> Chief Executive Officer	<b>Revised date:</b>	January 1, 2010