
17. MEMBER TRANSFERS AND DISENROLLMENT

- A. Primary Care Physician (PCP) Transfers
 - 1. Voluntary
-

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids 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.
- F. Under specific circumstances, Member transfers may be retroactive.

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A. Primary Care Physician (PCP) Transfers

1. Voluntary

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 10th 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
-

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids 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. 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 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

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A. Primary Care Physician (PCP) Transfers

2. Involuntary

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.

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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 Healthy Families and Healthy Kids Members.

POLICY:

- A. IEHP Healthy Kids Members may disenroll from IEHP at any time, for any reason, by submitting their signed request for disenrollment (letter or form) to IEHP Health Access.
- 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 Healthy Kids disenrollment decisions are handled entirely by IEHP Health Access, and final Healthy Families disenrollment decisions are handled by The California Managed Risk Medical Insurance Board.

PROCEDURE:

- A. Disenrollment forms for the Healthy Families Program are available through The California Managed Risk Medical Insurance Board, and disenrollment forms for the Healthy Kids Program are available through IEHP Health Access. Physician offices may not make copies of the disenrollment form.
- B. Requests for disenrollment through IEHP Health Access are handled in the following manner:
 - 1. IEHP Health Access 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 Health Access may be able to resolve the situation by explaining how membership with IEHP Health Access works, facilitating appointments, resolving service issues, etc.
 - 2. IEHP Health Access explains how a disenrollment form may be obtained and how the disenrollment process works, as follows:
 - a. For Healthy Families disenrollment request, IEHP Health Access provides the phone number and/or address/directions to The California Managed Risk Medical Insurance Board office.

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B. Disenrollment From IEHP

1. Voluntary

- b. For Healthy Kids disenrollment request, the Member must send a letter or a disenrollment form to IEHP Health Access. For Healthy Families disenrollment request, the Member must send a letter or disenrollment form to The California Managed Risk Medical Insurance Board office.
 - c. Disenrollment does not become effective for 15 to 45 days, depending on when the notification is given to IEHP Health Access or The California Managed Risk Medical Insurance Board by the Member, until that time the Member remains active in IEHP Health Access.
3. IEHP Health Access 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.
- D. Final Healthy Kids disenrollment decisions are handled entirely by IEHP Health Access, and Healthy Families disenrollment decisions are handled by The California Managed Risk Medical Insurance Board.

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17. MEMBER TRANSFERS AND DISENROLLMENT

B. Disenrollment From IEHP

2. Healthy Families Members

APPLIES TO:

- A. This policy applies to IEHP Healthy Families Members.

POLICY:

- A. Healthy Families (HF) Member disenrollments are administered wholly by the Healthy Families Program.

- B. Members may disenroll themselves by making a request in writing to the Healthy Families Program at the following address:

Healthy Families Program
Attn: Disenrollment
P.O. Box 138005
Sacramento, CA. 95813-8005

Or fax request to: (866) 848-4974

- C. Members may be involuntarily disenrolled from participation in the program if any of the following occurs:
1. The Member is found to no longer be eligible during the annual requalification period.
 2. The Member turns 19 years old.
 3. The Member is found to not be a citizen, a non-citizen national, or a qualified alien eligible to participate.
 4. The Member's application was falsified in any way in order to establish program eligibility.
 5. The Member fails to provide the necessary information to be requalified.
 6. The Member fails to pay their premium for 60 consecutive days after the due date.
- D. IEHP always attempts to resolve any problems and educate the Member on how the HF Program works in an effort to retain the Member. However, IEHP does not interfere with a Member's request to disenroll.

PROCEDURE:

- A. Disenrollment of HF Members is handled entirely by the Healthy Families Program.

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B. Disenrollment From IEHP

2. Healthy Families Members

- B. Member request for disenrollment received by IEHP Health Access are handled as follows:
1. IEHP Health Access explains that the Member may disenroll and requests information concerning the reason for the disenrollment to track and trend for IEHP quality issues. The Member is not required to provide justification. However, if reasons are provided, IEHP Health Access may be able to resolve the situation by explaining how membership in IEHP HF works, facilitating appointments, resolving service issues, etc.
 2. IEHP Health Access explains that the Member must send a letter to the Healthy Families Program and also provides the phone number and/or address for the Healthy Families Program.
 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.
 - d. The resolution of the call.
- C. Prior to disenrolling a Member, the Healthy Families Program sends written notification to the Member indicating the reason for and effective date of disenrollment. the Healthy Families Program may provide this notice as early as 30 days prior to disenrollment.
- D. The Healthy Families Program has full responsibility for HF disenrollments. They determine when and why a disenrollment will occur.
- E. The effective date of disenrollment may vary, per the Healthy Families Program:
1. Member requested disenrollment is effective as of the end of the last period for which the required monthly premiums were paid in full.
 2. Disenrollment due to the Member turning 19 years old is effective on the last day of the month in which the Member attained the age of 19.
 3. Disenrollment due to the Member's falsification of the application is effective immediately after the determination was made.

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B. Disenrollment From IEHP

2. Healthy Families Members

4. Disenrollment due to the Member's lack of eligibility at requalification or determination of non-citizenship is effective 30 days following the date of Member notification by the Healthy Families Program.
- F. A Member who voluntarily disenrolls, is disenrolled due to non-payment of premiums or is unable to provide necessary information at time of requalification may not participate in the program for six months from the date of disenrollment. However, this exclusion may be waived if the Member provides documentation that the reason for disenrollment was due to one of the following:
1. The Member or other family member lost employment;
 2. The Member or other family member suffered a catastrophic illness which resulted in the Member or other family member being unable to work for more than two weeks; or
 3. The Member became eligible for no cost, full-scope Medi-Cal.

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17. MEMBER TRANSFERS AND DISENROLLMENT

- B. Disenrollment from IEHP
 - 3. Healthy Kids Members
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APPLIES TO:

- A. This policy applies to IEHP Healthy Kids Members.

POLICY:

- A. Healthy Kids (HK) Member disenrollments are administered entirely by IEHP Health Access.
- B. Members may disenroll themselves by making a request in writing to IEHP Health Access at the following address:

Inland Empire Health Plan
Attn: Healthy Kids Enrollment
P.O. Box 19026
San Bernardino, CA 92423-9026

- C. Members may be involuntarily disenrolled from participation in the program if any of the following occurs:
 - 1. The Member is found to no longer be eligible at any time during the one-year period of eligibility due to financial status, residency or other program eligibility requirements.
 - 2. The Member or Member's family fails to provide the documentation and/or application fee required for the annual requalification process.
 - 3. The Member turns 19 years old.
 - 4. The Member moves out of Riverside or San Bernardino County.
 - 5. IEHP Health Access determines that false declarations were intentionally or willfully made to establish or maintain program eligibility.
 - 6. The Member or Member's family refuses participation in the CCS program or neglects to complete CCS enrollment requirements.
 - 7. The Member demonstrates substantial non-compliance with the practitioners recommended treatments.
 - 8. The Member no longer meets the funder's eligibility requirement.
 - 9. The program funder terminates the contract, no longer funds the program, or reduces funding.
- D. IEHP Health Access always attempts to resolve any problems and educate the Member on how the HK Program works in an effort to retain the Member. However, IEHP Health

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B. Disenrollment from IEHP 3. Healthy Kids Members

Access does not interfere with a Member's request to disenroll.

PROCEDURE:

- A. Disenrollment of HK Members is handled entirely by IEHP Health Access.
- B. Member request for disenrollment received by IEHP Health Access are handled as follows:
 - 1. The Member calls IEHP Member Services and requests disenrollment.
 - a. IEHP Health Access requests information concerning the reason for disenrollment to track and trend for IEHP Health Access quality issues however, the Member is not required to provide justification.
 - b. If the Member provides a reason for disenrollment, IEHP Health Access tries to resolve the Member's issues when appropriate, by explaining how membership in IEHP HK works, facilitating appointments, resolving service issues, etc.
 - c. IEHP Health Access explains how disenrollment may be obtained and how the disenrollment process works as follows:
 - 1) The Member must send a letter to IEHP Health Access requesting disenrollment.
 - 2) Disenrollment does not become effective for 15 to 45 days, depending on when the notification is given to IEHP Health Access by the Member, until that time the Member remains active in IEHP Health Access.
 - 2. IEHP Health Access logs the call documenting the following:
 - a. Member's name and IEHP ID number.
 - b. The reason for the call.
 - c. Any attempt made to resolve any issues.
 - d. The resolution of the call.
- C. Prior to disenrolling a Member, IEHP Health Access sends written notification to the Member indicating the reason for and effective date of disenrollment. IEHP may provide this notice as early as 30 days prior to disenrollment.
- D. The effective date of disenrollment may vary as follows:
 - 1. Member requested disenrollment is effective as of the end of the month during which IEHP Health Access processes the disenrollment request.

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B. Disenrollment from IEHP

3. Healthy Kids Members

2. Disenrollment due to the Member turning 19 years old is effective on the last day of the month in which the Member attained the age of 19.
 3. Disenrollment due to the Member's intentional or willful falsification of the application is effective immediately after the determination is made.
 4. Disenrollment due to the Member's lack of eligibility is effective 30 days following the date of Member notification by IEHP Health Access.
 5. Disenrollment due to the Member's refusal of CCS participation or failure to complete the CCS enrollment process is effective 30 days following the date of Member notification by IEHP Health Access.
- E. Upon disenrollment for any reason, there is no automatic "reinstatement." Members will have to reapply, including submission of an additional application fee to re-enter the program after disenrollment.
- F. Requests for reinstatement after disenrollment for cause will be reviewed on a case-by-case basis. It is at the sole discretion of IEHP Health Access to reinstate in these cases.

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17. MEMBER TRANSFERS AND DISENROLLMENT

C. Continuity of Care

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids 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 2nd and 3rd 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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C. Continuity of Care

- 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. 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.
- E. 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.
- F. 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 notified in writing.
- G. 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.
- H. Members can request assistance or ask questions about continuity of care by calling IEHP

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C. Continuity of Care

Member Services.

- I. 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.
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.

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C. Continuity of Care

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 a terminating provider 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 undergoing 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. Acute conditions will be reviewed within 5 days. Non-urgent conditions will be reviewed within 10 days.
3. 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 the right to keep your provider for a designated time period. Please contact your Health Plan'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."*
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.
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 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 may do one or all of the following:

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C. Continuity of Care

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 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 will offer 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. 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).
4. Ensure continuity of care for Members meeting criteria specified in Section A of this policy.
5. 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.
6. Re-assign all block transferred Members within DMHC's geographic access standards, as applicable.
7. Assess the receiving Provider's administrative and financial capacity to accept and maintain the block transfer.
8. The Provider Services Department, in cooperation with the Operations Department at IEHP, is responsible for the notification and re-assignment of Members.
9. In the case of a contract termination with a hospital, IEHP will verify that there is an alternate hospital located within the DMHC's geographic access standard for all assigned Members.
10. Ensure that Members have the same range of services that are within DMHC's standards of care.

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C. Continuity of Care

11. 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

D. Episode of Care - Inpatient

APPLIES TO:

- A. This policy applies to all IEHP Healthy Families and Healthy Kids 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. New Member Enrollment
1. 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.
 2. The IPA must be involved in the care management and discharge planning of the Member.
- B. Member No Longer Eligible With IEHP
1. If 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.
- C. Member Requested PCP Change
1. If a Member requests a PCP change prior to being hospitalized (e.g. Member calls on May 5th 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

17. MEMBER TRANSFERS AND DISENROLLMENT

D. Episode of Care - Inpatient

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 Members 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		
Chief Approval: <i>Signature on file</i>	Effective date:	September 1, 1996
Chief Title: Chief Executive Officer	Revised date:	August 1, 2007