KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Provider Termination				POLICY #: 4.39-P	
DEPARTMENT: Provider Relations					
Effective Date: 1-26-2017	Review/Revised Date:	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 1/26/17

Chief Medical Officer — Date

Chief Operating Officer — Date 1/23/17

Director of Claims — Date 1-20-17

Director of Compliance and Regulatory Affairs — Date 1-17-17

Director of Provider Relations — Date 1/17/17

POLICY:
Kern Health Systems (KHS) shall follow the protocol and notification requirements for the termination of a subcontracted provider of health care services in accordance with regulatory requirements. This policy provides protocols for subcontracted provider terminations that are initiated by KHS and it also provides requirements pertaining to the suspension, termination, or decertification of a provider from participation in the Medi-Cal Program when initiated by the state.

DEFINITIONS:

Block Transfer	A transfer of 2,000 or more members from a terminated IPA, medical group, or hospital.
Independent Practice Association (IPA)	An organization that contracts with independent physicians.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a Primary Care Physician or Non-Physician Medical Practitioner.
Subcontract	A written agreement entered into by KHS with any provider of health care services who agrees to furnish covered services to Members; any other organization or person(s) who agree(s) to perform any function or service for KHS specifically related to fulfilling KHS' obligations to DHCS under the terms of KHS' contract with the Department of Health Care Services (DHCS).
Sub-Subcontractor	Any party to an agreement with a subcontractor descending from the subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under KHS' contract with the (DHCS).

PROCEDURES:

KHS INITIATED PROVIDER TERMINATION

KHS shall obtain written approval from DHCS prior to making any substantial change in the availability or location of covered services when terminating a contract with a subcontracted provider, clinics and PCPs, IPAs and medical groups, or hospitals. KHS shall coordinate the transfer of care for members who are assigned to and/or receiving care from the terminating provider and shall follow continuity of care requirements per Policy 3.39-P *Continuity of Care by Terminated Providers.*

All member notices, narratives, continuation notices or Block Transfer notices must be submitted to the Compliance Department for review and submission to the Department of Health Care Services (DHCS) and/or the Department of Managed Health Care (DMHC). The Compliance Department will work with the DHCS and /or DMHC to facilitate approval of required documents.

KHS will file with the DMHC a Block Transfer filing via the DMHC portal at least seventy-five (75) days prior to the expected termination or non-renewal date of a provider contract or general acute care hospital contract.

1.0 Subcontracted Providers

At least sixty (60) days prior to the date of termination, Member Services shall draft a member notice and Provider Relations shall draft a narrative that explains how KHS intends to continue to provide covered services to affected members to be submitted to DHCS for review and approval. The member notice must be mailed to members thirty (30) days prior to the effective date of the termination.

1.1 Member Notice

Member Services shall draft a member notice for members who will have to change their provider which at a minimum includes:

- The effective date of the termination;
- The name of the member's current provider and the name of the new provider to which the member will be assigned;
- A description of how the termination will affect the member's access to covered services;
- If the member must change providers, the member will either be assigned a new provider with the option to change that provider, or the member may have the opportunity to choose a new provider within thirty (30) days from the date of the letter and be assigned a new provider if the member does not choose one;
- If the member is receiving services on an ongoing basis and must change providers, the member should be notified of the pending transition;
- All language required by the H&S Code § 1373.65(f) in not less than 8-point type: "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.
- Member Services phone numbers and the toll-free telephone numbers of the DHCS' Office of the Ombudsman.

1.2 Narrative

Provider Relations and Member Services shall draft a narrative that explains how KHS intends to continue to provide covered services to affected members which includes:

- The reason for the provider termination;
- The date the member notice will be mailed;
- The number of members assigned to the terminating provider;
- If Applicable, A "crosswalk" showing the number of members and the names of the providers to which these members are reassigned in order to retain contractual access;
- The number of members who will be assigned to a provider who is outside contractual access standards and cannot retain access through reassignment to another provider who would meet contractual access standards;
- The number of members who cannot be assigned to a new provider within the required time and distance standards of thirty (30) minutes or ten (10) miles;
- The number of members receiving ongoing care who must be transitioned to another provider; and
- A copy of DMHC's block transfer filing if applicable, or assistance with DMHC to access the block transfer filing.

This narrative will be submitted to DHCS for approval.

2.0 Clinics and PCPs

When a contract termination for a clinic or PCP will result in more than 500 members having to change their PCP, KHS shall submit notice to DHCS as outlined in § 1.0 of this policy. In cases where the contract termination will result in less than 500 members having to change their clinic or PCP, and all affected members can be reassigned to PCPs within the time and distance standards, KHS shall use a boilerplate member notice (Attachment A) that was previously approved by DHCS each time such a termination occurs.

2.1 Member Notice

Member Services shall draft a member notice or use the member notice boilerplate that was previously approved by the DHCS which shall include:

- The effective date of the termination;
- The name of the terminating clinic or PCP;
- A description of how the termination will affect the member's access to covered services;
- The opportunity to choose a new PCP, or be assigned to a new PCP with the option to change if the member does not choose a PCP;
- All required H&S code language;
- Member Services telephone numbers and the toll-free telephone number for the DHCS' Office of the Ombudsman.

2.2 Narrative

Provider Relations and Member Services shall draft a narrative of how KHS intends to continue to provide covered services to affected members which includes:

- The reason for the termination;
- The date the member notice will be mailed;
- The number of members assigned to the terminating clinic or PCP;
- The number of members who cannot be assigned to a new clinic or PCP within the time and distance standards; and
- A copy of the DMHC block transfer filing if applicable, or assistance with working with the DMHC to access the block transfer filing.

3.0 IPA/Medical Groups

All IPA and medical group contract terminations constitute a substantial change in the availability or location of covered services and require notice to the DHCS. In addition to the notice requirements in § 1.0 of this policy, the member notice is to include whether the member must change their PCP or specialist and/or how the member will maintain access to services.

4.0 Hospitals

All hospital contract terminations constitute a change in the availability or location of covered services and require notice to the DHCS. At least thirty (30) days prior to the termination of a contract, KHS must submit the member notice as well as a description of how KHS intends to continue to provide covered services to affected members to DHCS for review and approval. The member notice must be mailed no more than five (5) days after the termination to members who received services within the last twelve (12) months and are scheduled to receive services within the next six (6) months at the terminating hospital.

4.1 Member Notice

Member Services shall draft a member notice to be submitted to the DHCS for review and approval. In addition to the notification requirements in § 1.1 of this policy, the member notice should include:

- If applicable, the name of the member's current PCP, the name of the PCP selected by the member, or the PCP the member will be assigned to with the option to change; and
- If applicable, the name of another hospital the member will be assigned to, or can access in the service area.

4.2 Narrative

Provider Relations and Member Services shall draft a narrative that describes how KHS intends to continue to provide covered services to the affected members to be submitted to the DHCS for review and approval. The narrative should include:

- The number of members who will need to change PCPs due to the terminating hospital having a primary care clinic, or having a PCP with admitting privileges only at the terminating hospital;
- The number of members who do not need to change PCPs, but will rely on hospitalists to access hospital services;
- The number of members who will need to change PCPs and cannot be reassigned to another PCP within the time and distance standards;
- The number of members who must change specialists due to the termination;
- The number of members who must change specialists due to the termination and do not have access to another appropriate specialist within thirty (30) miles;
- A list of specialty services available at the terminating hospital not available at other hospitals within thirty (30) minutes or fifteen (15) miles from the terminating hospital; and
- A list of contracted hospitals within thirty (30) minutes or fifteen (15) miles of the terminating hospital.

5.0 Successful Negotiation of Agreement

If KHS successfully negotiates an agreement with a subcontracted provider, clinic or PCP, IPA or medical group, or a hospital after sending notice of termination to affected members, KHS shall send another notice to inform members of the continuation of the contractual relationship. KHS shall immediately inform and submit a notice to DHCS for review and approval. Member Services shall draft a member notice that will include:

- An explanation that an agreement has been reached with the subcontracting entity;
- An explanation of the member's option to remain with, or change providers;
- All language required by H&S Code; and
- Member Services telephone numbers and the toll-free telephone number for the DHCS' Office of the Ombudsman.

6.0 Right to Hearing

In the case where KHS initiated provider contract termination is the result of disciplinary action, a provider may have the right to request a hearing in accordance with KHS Policy 4.35-P – *Provider Hearings.*

7.0 Federal and/or State Initiated Suspensions, Terminations, and Decertification's

DHCS is required to suspend Medi-Cal providers from participation in the Medi-Cal program when an individual or entity has:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reason;
- Lost or surrendered a license, certificate, or approval to provide health care; or
- Breached a contractual agreement with DHCS that explicitly specifies inclusion on the Suspended and Ineligible Provider List as a consequence of the breach, thus providers cannot be paid post the effective suspension, termination, or decertification date.

The following requirements apply to federal and/or state-initiated suspensions, terminations, and decertification of a provider and to all provider types unless listed as an exception to the thirty (30) day requirement. In the case of an immediate closure of a provider by the California Department of Public Health (CDPH), CDPH is responsible for the transition of all the affected members; KHS shall track these members and coordinate care as needed.

Upon discovery that a KHS contracted provider has been suspended, terminated, or decertified from the Medi-Cal program KHS shall immediately:

- Communicate the notification to all related downstream entities including subcontractors and delegated entities;
- Ensure the provider receives no payment for Medi-Cal services provided on or after the effective date of action; and
- Maintain ongoing communication with DHCS about the transition of any affected members.

  After receiving final notification of a provider suspension, termination, or decertification, KHS shall:
- Communicate the provider termination notice to all related delegated entities, subcontractors, impacted members or the member's guardian, conservator, or personal representative as applicable within three business days; and
- Ensure the safe transition of members to a new provider for services.

Within three (3) business days of receiving final notification, KHS shall provide DHCS with KHS' contract status, or the KHS delegated entity's contract status with the named provider and the number of members receiving services from the provider whether contracted with KHS or a delegated entity of KHS.

Within five (5) business days of receiving final notification, KHS shall submit a transition plan to DHCS for approval that includes:

- A timeline for prompt transition of affected members no sooner than thirty (30) days after notification of the Medi-Cal action unless the member wishes to move sooner;
- A timeline for KHS' care manager to contact and speak with all affected members;
- A process to consult with the Long Term Care Ombudsman and other related entities as appropriate;
- A process to work with affected members, guardians, conservators, or personal representatives, as applicable, regarding the transition and the member's options or choices; and
- A process for the review of all the affected members' medical records including a process for communication with members' providers as appropriate.

The member notice shall include:

- The effective date of the termination;
- The name of the provider;
- A description of how the suspension, termination, or decertification will affect the member's access to covered services;
- All language required by the H&S Code and the Knox-Keene Act;
- Language providing the member with Member Services telephone number and the toll-free telephone number of DHCS's Office of the Ombudsman for questions or concerns;
- A description of how KHS maintains the ability to continue to provide covered services to affected members;
- The reason for the suspension, termination, or decertification; and
- The date the member notice will be mailed.

Members who choose not to transition to a new provider will be informed that they may become responsible for the costs of the services provided by the suspended, terminated, or decertified provider.

All submissions, communications and updates should be sent to: pmmp.monitoring@dhcs.ca.gov.

ATTACHMENTS:

- Attachment A – Member Notice of Primary Care Provider Termination

REFERENCE:

Revision 2016-12: New policy created to comply with All Plan Letter 16-001

1- Title 22 CCR §§ 53885; 53922.5 and Exhibit A, Attachment 6, Provider Network, Time and Distance Standard
2- Health and Safety Code § 1373.65(e)
3- Welfare and Institutions Code §§ 14043.6; 14123

[DATE TO BE MAILED]

RE: Member Notice of Primary Care Provider Termination

Dear Kern Family Health Care Member,

Thank you for choosing Kern Family Health Care (KFHC) as your health plan. Our records indicate that you have selected **[PROVIDER NAME]** as your Primary Care Provider (PCP). Effective [EFFECTIVE DATE], **[PROVIDER NAME]** will no longer be assignable as a PCP with KFHC. From [DATE RANGE] you can go to any contracted KFHC PCP for primary care services. You have from now until [DATE], to choose a new PCP to be assigned to on [DATE]. If you do not choose one by [DATE], we will assign one to you on [DATE]and send you a letter.

In order to improve the quality of care provided to our members, KFHC wants to help you establish a medical home with a single PCP who will coordinate all of your health care needs. **KFHC members cannot receive primary care services from a PCP they are not assigned to. You must see the PCP or clinic you are assigned to for primary care services. If you go to a PCP you are not assigned to, that PCP will NOT see you and will tell you that you must go to your assigned PCP.** The longer you are treated by your PCP, the better he or she will be able to manage your health care. **If you are not happy with your PCP, you can change your PCP once a month.**

You can find a list of PCPs in the KFHC Provider Directory or you can visit our website: www.kernfamilyhealthcare.com. To choose a new PCP or to request a copy of the Provider Directory, call the Member Services Department, Monday through Friday, 8:00 am to 5:00 pm, at (661) 632-1590 or 1-800-391-2000. The hearing impaired may contact our Member Services Department through the California Relay Service at 1-800-735-2929.

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.

YOUR BENEFITS
A change in PCP will not affect your benefits or your ability to receive medical care.

BILLING
Your current PCP may not bill you for covered services. If you receive a bill, please contact our Member Services Department immediately.

Again, thank you for choosing Kern Family Health Care.

Para español vea al reverso

IMPORTANT: Can you read this letter? If not, we can have somebody available to help you read it. You may also be able to get this letter written in your language. For free help, please call Kern Family Health Care's Member Services Department at (661) 632-1590 or 1-800-391-2000 right away.
MS1037

RE: Noticia al miembro de terminación del Proveedor de Cuidado Primario

Estimado miembro de Kern Family Health Care,

Gracias por elegir a Kern Family Health Care (KFHC) como su plan de salud. Nuestros expedientes indican que usted eligió a **Oriente Esposo, MD** como su Proveedor de Cuidado Primario (PCP). Efectivo el 18 de junio del 2014, **Oriente Esposo, MD** no será un PCP contratado con KFHC. Del día 18 de junio del 2014 al 30 de junio del 2014, usted puede ir a cualquier PCP contratado con KFHC para servicios de cuidado primario. Usted tiene desde ahora hasta el 24 de junio del 2014 para elegir un nuevo PCP para ser asignado el día 1ro de julio del 2014. Si usted no elige uno para el día 24 de junio del 2014, nosotros le asignaremos uno a usted y le enviaremos una carta.

A fin de mejorar la calidad del cuidado que se proporciona a nuestros miembros, KFHC quiere ayudarle a establecer un hogar médico con un solo PCP que coordinará todas sus necesidades del cuidado de salud. **Los miembros de KFHC no pueden recibir servicios de cuidado primario de un PCP al que no están asignados. Usted debe consultar con el PCP o clínica que se le asigna para servicios de cuidado primario. Si usted va a un PCP al cual usted no está asignado, el PCP NO lo(a) verá y le dirá que debe ir a su PCP asignado.** Entre más tiempo sea usted tratado por su PCP, él o ella podrá administrar su cuidado médico mejor. **Si usted no está contento con su PCP, sólo puede cambiar su PCP una vez al mes.** Las solicitudes presentadas hasta el día 24 del mes serán efectivas el primer día del mes siguiente. Las solicitudes hechas después del día 24 del mes serán efectivas a partir del primer día del segundo mes siguiente a la solicitud.

Usted puede encontrar la lista de PCPs en el Directorio de Médicos de KFHC o puede visitar nuestra página del Internet: www.kernfamilyhealthcare.com. Para elegir un nuevo PCP o para pedir una copia del Directorio de Proveedores, llame al Departamento de Servicios para Miembros al (661) 632-1590 o 1-800-391-2000 de lunes a viernes de las 8am a las 5pm. Las personas con dificultades auditivas pueden llamar a nuestro Departamento de Servicios para Miembros por medio del Servicio de Retransmisión de California al 1-800-735-2929 en inglés o al 1-800-855-3000 en español.

Si usted tiene más preguntas o necesita más asistencia, usted puede llamar al Department of Health Care Services Office of the Ombudsman Unit al 1-888-452-8609.

SUS BENEFICIOS
El cambiar de PCP no afectará sus beneficios o el que usted pueda recibir cuidado médico.

FACTURAS
Su actual PCP no le puede cobrar por servicios cubiertos. Si usted recibe una factura, por favor llame al Departamento de Servicios para Miembros inmediatamente.

Nuevamente, gracias por elegir a Kern Family Health Care.

English on the other side

IMPORTANTE: ¿Puede leer esta carta? Si no, nosotros le podemos tener a alguien disponible que le puede ayudar a leerla. Además, usted puede recibir esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al Departamento de Servicios para Miembros al (661) 632-1590 o 1-800-391-2000.

MS1037