KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Provider Termination				POLICY #: 4.39-P	
DEPARTMENT: Provider Network Management / Member Services					
Effective Date: 1/26/2017	Review/Revised Date: 3/7/2022	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ Date _____
Director of Member Services

POLICY:
Kern Health Systems (KHS) shall follow the protocol and notification requirements for the termination of a Network Provider of health care services in accordance with regulatory requirements. This policy provides protocols for Network Provider[1] terminations, member notices, and it also provides

[1] As defined in APL 19-001, *Medi-Cal Managed Care Health Plan Guidance on Network Provider Status*.

requirements pertaining to the suspension, termination, or decertification of a provider from participation in the Medi-Cal Program when initiated by the state.

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 network agreement or general acute care hospital agreement.

DEFINITIONS:

Block Transfer	A transfer of 2,000 or more members from a terminated provider, medical group, or hospital.
Significant Termination	A termination resulting in an impact of 2,000 or more members, or non-compliance with any of the Annual Network Certification components.

PROCEDURES:

Voluntary Network Provider Termination

When KHS or Network Provider voluntarily terminates a Network Provider agreement, KHS will complete the following:

1. Provide notice to all impacted members as described in APL 21-003, *Medi-Cal Network Provider and Subcontractor Terminations*

2. Notify all affected directly contracted providers of the Network Provider agreement termination, as applicable

3. Coordinate care for impacted members as required by federal and state law, and the Plan's contract with DHCS

4. Significant terminations resulting in an impact of 2,000 or more members, or non-compliance with any of the Annual Network Certification components will require: At least 60-days prior to the effective date of a voluntary provider network agreement termination, or immediately upon learning of the termination from the Network Provider, provide DHCS with written notice of the termination, a Transition Plan, and Network Review Documents, as described in APL 21-003, *Medi-Cal Network Provider and Subcontractor Terminations*

Network Provider Agreement Terminations Resulting from a Network Provider's Exclusion from Participation in the Medi-Cal Program

Exclusionary databases must be reviewed on a regular basis, and at least monthly. Upon discovery that a Network Provider has been excluded or suspended from the Medi-Cal program, KHS must take the following steps:

1. Immediately, or within 10 calendar days of learning of a Network Provider's exclusionary status, suspend payment to the excluded Network Provider for all Medi-Cal services provided after the effective date of the exclusion

2. Immediately, or within 10 calendar days of learning of a Network Provider's exclusionary status, notify all affected Network Providers, as applicable

3. Provide notice to all impacted members as described in APL 21-003, *Medi-Cal Network Provider and Subcontractor Terminations*

4. Coordinate care for impacted members as required by federal and state law, and KHS contract with DHCS

5. Report to DHCS program integrity information related to fraud, waste and abuse allegations, including any Network Provider agreement terminations, as described in the "Monitoring, Oversight, and Reporting" section of APL 21-003 *Medi-Cal Network Provider and Subcontractor Terminations*, KHS contract with DHCS, and as further required by DHCS

6. Significant terminations resulting in an impact of 2,000 or more members, or non-compliance with any of the Annual Network Certification components will require: immediately, or within 10 calendar days of learning of a Network Provider's exclusionary status, provide DHCS with written notice of the termination, submit a Transition Plan, and Network Review Documents as described in APL 21-003, *Medi-Cal Network Provider and Subcontractor Terminations*

Member Notices

The Plan is required to provide written notice to all impacted members informing them of a Network Provider agreement termination either 30 calendar days prior to the effective date of the agreement termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later, unless directed by DHCS.

If the Plan is notified of a Network Provider agreement termination less than 30 days prior to the effective date of the termination, the Plan must immediately notify all impacted members of the termination.

Member notice must include the following information:

- Effective date of the Network Provider agreement
- A description of how the Network Provider agreement termination will impact the member's access to covered services, if applicable
- Name of the terminating/terminated Network Provider
- Name of the new Network Provider that the member is being assigned to, if applicable
- Member rights information on how to request a new provider if the member elects to change from the provider the Plan reassigned them to

- If applicable, the name of another hospital the member will be assigned to or can access in the service area
- All language required by HSC section 1373.65, including the member's continuity of care (C.O.C.) rights to the terminating/terminated Network Provider, unless the Network Provider has been excluded from participating in the Medi-Cal Program
- Language providing the member with the Plan's Member Services telephone number and the toll-free telephone number of DHCS' Office of the Ombudsman.

Adjustments to previously approved member notice templates must be submitted to DHCS for approval prior to sending the notice to members. If the Plan does not have prior DHCS approval on a member notice template, the Plan must submit the notice for DHCS review and approval no later than 60 days prior to the effective date of the termination. The Plan may use a DHCS-approved member notice template regardless of the number of members impacted by the termination. However, if there are any changes from the approved template, the Plan must submit the member notice to DHCS 60 days prior to the effective date of the termination for review and approval prior to mailing the notice.

In the event member letters were sent out advising of a voluntary provider network agreement termination which was renegotiated prior to the Network Provider agreement termination date, the Plan must mail members another letter informing members the agreement will remain in effect. The letter must include:

- An explanation that an agreement has been reached with the Network Provider
- An explanation of the member's option to remain with, or change Network Providers
- All language required by HSC section 1373.65
- The Plan's Member Services telephone number and the toll-free telephone number of DHCS' Office of the Ombudsman

Transition Plan

The Plan must submit a transition plan to DHCS for the purposes of assessing network impact due to a Network Provider agreement termination.

General Information

- The name of the terminating/terminated Network Provider
- The proposed effective date of the Network Provider agreement termination
- The reason for the Network Provider agreement termination
- The date the member notice will be mailed
- A description of administrative actions, which includes: notifying call center staff about the Network Provider agreement termination, removing the terminated Network Provider from the auto-assignment system, and ceasing payments for terminated or suspended Network Providers

Member Impact

- The number of members impacted by the terminating/terminated Network Provider
- A "crosswalk" showing the number of members and the names of the new Network Providers to which the members will be reassigned within time or distance standards

- The number of members that must be reassigned to new Network Providers and continue to have access to another Network Provider within time or distance standards
- The number of members that will be reassigned to a Network Provider that is outside of time or distance standards and cannot retain access through another Network Provider within time or distance standards

Hospital and Facility Information (if applicable)

- If applicable, a list of specialty services available at the terminating hospital that are not available at other hospitals within time or distance standards
- If applicable, a list of network hospitals that the Plan could contract with or are contracted with within time or distance standards of the terminating hospital
- If applicable, the number of members who will need to change Primary Care Providers (PCPs) due to the terminating hospital having a primary care clinic, or having a PCP with admitting privileges only at the terminating hospital
- If applicable, the number of members who will need to change specialists due to the terminating hospital having a specialty care clinic or group, or having specialists with admitting privileges only at the terminating hospital

California Department of Public Health Initiated Facility De-certifications and Suspensions

The California Department of Public Health (CDPH) is responsible for decertifying or suspending licensed Long-Term Care (LTC) facilities and in the event of an immediate decertification is responsible for the transition of members; the Plan will work with the facility to ensure that members continue to receive medically necessary covered services.

Network Providers, including LTC facilities are required to notify the Plan upon receiving a decertification notification from CDPH.

Upon discovery of an LTC facility decertification or suspension, the Plan must terminate its provider network agreement with the facility, and take the following steps outlined below:

1. Immediately notify DHCS of the provider network agreement termination with the LTC facility due to decertification or suspension

2. Within five business days of receiving a final notification of an LTC facility decertification, submit a Transition Plan and Network Review Documents as described in APL 21-003, *Medi-Cal Network Provider and Subcontractor Terminations*

3. Immediately suspend payment to the decertified or suspended LTC facility for all Medi-Cal services provided after the effective date of the exclusion

4. Immediately notify all affected Network Providers of the decertified or suspended LTC facility

5. Provide notice to all impacted members as described in the “Member Notice” section

6. Coordinate care for impacted members as required by federal and state law, and the Plan’s contract with DHCS

A. Transition Plan

The Plan must submit a Transition Plan to DHCS for approval, regardless of the number of members impacted, and at a minimum must include:

- A timeline for prompt transition of impacted members no sooner than 30 days after notification of the decertification, unless the member wishes to move sooner
- A timeline for the Plan case manager to contact and speak with all impacted members
- A process to consult with the LTC Ombudsman and other related entities, as appropriate
- A process to work with impacted members, guardians, conservators, or personal representatives, as applicable, regarding the transition and the member's options or choices
- A process for the review of all impacted members' medical records, including a process for communication with members' providers as appropriate
- A plan of action to ensure that members' personal belongings are transitioned to the members' new providers in a timely manner

B. The Plan must provide a DHCS approved notice to members within five days of receiving notification of the closure or effective date of the termination, and at a minimum must include the following information:

- The effective date of the Network Provider agreement termination
- The name of the LTC facility
- The reason for the decertification
- A description of how the decertification will impact the member's access to covered services
- All language required by HSC and the Knox-Keene Act
- Language providing the member with the Plan's Member Services telephone number and the toll-free telephone number of DHCS' Office of the Ombudsman for questions or concerns
- A description of how the Plan will maintain the ability to provide covered services to impacted members
- The date the member notice will be mailed

If the facility is residential and remains open, members must have at least 30 days post-notice to transition to a new facility, with the following exceptions:

- The safety of a member in a facility (e.g., SNF) is endangered

• The health of a member in a facility is endangered

• A member's health improves sufficiently so that the member no longer requires the services provided by the facility

• A member's urgent medical needs require an immediate transfer or discharge

• A member has not resided in a facility for 30 days or more

• A member, their guardian, conservator, or personal representative has requested a transition to another facility

• A facility closes or is no longer operational

Members may choose to not transition to a new facility; however, they may be responsible for the costs of the services provided by the terminated or decertified facility and must be informed of this if they choose not to transition.
The aforementioned requirements pertaining to federal and/or state-initiated suspensions, de-certifications, and exclusions from the Medi-Cal program are applicable across all the various provider types, unless listed as an exception to the 30-day stay requirement.

In the case of an immediate closure of a provider by CDPH, CDPH is responsible for the transition of all affected members residing in the facility. The Plan is responsible for tracking the transition of impacted members and coordinating care as needed.

Member Access and Protections
The Plan is required to allow the following protections to ensure continued access and avoid disruption in care for members impacted by Network Provider.

Continuity of Care
The Plan is responsible for authorizing C.O.C. to Network Providers whose provider network agreements with the Plan have been terminated. The Plan is exempt from authorizing C.O.C. if the provider was terminated for exclusionary reasons related to a medical disciplinary action, fraud, abuse, or other conduct that prohibits the provider from participating in the Medi-Cal program. The Plan must reference APL 18-008 or any superseding APL for more information about C.O.C.

Out-of-Network Access
The Plan is responsible for ensuring the safe transition of members to new Network Providers when a provider network agreement termination occurs. When a Network Provider Agreement is terminated effective immediately and if there are no in-network providers available for members to be reassigned to, the Plan must allow out-of-network access and/or make the Plan's entire network available to impacted members to ensure that the members do not experience a disruption in care.

Payments and Rates
If the Plan pays a suspended or decertified provider for services provided after the provider exclusion date, he Plan must not include those payments in the rate development template. The Plan may include provider network agreement provisions with Network Providers stating that services provided to Medi-Cal members after the provider has been decertified, suspended, or excluded from the Medi-Cal program are not eligible to receive state or federal reimbursement (i.e.; Medi-Cal funding) and may

not be collected from the member. Network Providers placed on payment suspension are eligible to remain contracted with the Plan; however, the Plan must ensure that the Network Provider does not receive reimbursement for services provided to members until the payment suspension has been lifted and the provider is not seeking payment from members.

Delegation

The Plan is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. The Plan will communicate the policy requirements to all delegated entities and subcontractors. The Plan will ensure that all of their own policies and procedures, as well as the policies, procedures, and practices of any delegates, sub plans, contracted providers, or subcontracted Independent Physician Associations or medical groups, comply with these requirements and those located in any applicable APL.

REFERENCE:

Revision 2021-07: Policy approved by DHCS Contract Manager 7/27/2021. Policy revised to comply with All Plan Letter 21-003. **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