Continuity of Care and Provider Rights

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When a health care service plan (“Plan”) or an Independent Practice Association (“IPA”) terminates its contract with a provider, enrollees have certain continuity of care rights which permit them to continue care and treatment with the terminated provider. Providers want to keep seeing the enrollees, enrollees often want to keep seeing the providers, and Plans and IPAs want the exact opposite. Plans and IPAs are concerned about the additional costs associated with continuity of care, and as significantly, the concern that the enrollee will become so attached to the provider that he will switch to a competing Plan or IPA. To ensure that the enrollees’ continuity of care rights are not compromised in the contract termination process, there are laws and regulations governing the process by which enrollees are notified of the termination. If a health care service plan does not comply with these regulations, the provider may wish to notify the Department of Managed Health Care (“DMHC”), send out its own communication to the enrollee that is compliant with the applicable rules and regulations, and/or pursue legal action and seek, among other things, injunctive relief to prevent any further interference with the doctor-patient relationship.

Under California law, Plans are licensed and regulated by the DMHC under the Knox-Keene Health Care Service Plan Act of 1975 (“Knox-Keene Act”). Health & Safety Code §§ 1340 et seq. Included within the enumerated goals of the Knox-Keene Act is to ensure “the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional” [Health & Safety Code § 1342(a) (2)], and to ensure “that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care” [Health & Safety Code §1342(g), emphasis added].

Essentially three statutes are relevant to this discussion. Section 1373.96 establishes the right to continuity of care and sets forth the circumstances in which a patient has the right to complete treatment with a terminated provider.1 Section 1373.95 requires health care service plans to submit to the DMHC its continuity of care policy and plans in the event of a provider termination, including any termination notice to patients. Section 1373.65 requires

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1 The terms “continuity of care” and “agency” are defined as follows under California law: “continuity of care” means the uninterrupted and unbroken care of a patient or his family or household by a health care provider, agency, or hospital; and “agency” means any person, facility, entity, or organization engaged in providing health care services in this state. [Health & Safety Code § 1373.65]
a health care service plan to give advanced notice of a provider termination, using a preapproved notice.

**Enrollee’s Continuity of Care Rights To Continue Treatment With Terminated Provider**

Sections 1373.65, 1373.95 & 1373.96 impose certain continuity of care requirements on Plans. “Health care service plan” is broadly defined to mean any person who arranges for “the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.” Health & safety Code §1345(f)(1). IPAs fall within this definition and, as a result, the discussion herein equally applies to IPAs. California Prac. Guide, Insurance Litigation Chs.6:920, 6:921; see California Medical Ass’n, Inc. v. Aetna US. Healthcare of California, Inc. (2001) 94 Cal. App.4th 151, 156-157, n. 5&6.

Where a terminated provider has been providing treatment for an acute condition, a terminal illness, a planned surgery or other procedure (to occur within 180 days of the contract’s termination date), or the care of a newborn child between birth and age 36 months, Section 1373.96 requires that a Plan shall, at the request of an enrollee, complete the care of the enrollee for the duration of the acute condition or illness. Health & Safety Code §1373.96(c)(1) and (c)(4). Respecting a serious chronic condition, “[c]ompletion 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 the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice,” but shall not exceed 12 months from the contract termination date. Health & Safety Code §1373.96(c)(2).

If an enrollee’s condition or treatment qualifies under Section 1373.96, continuity of care rights are triggered and the Plan shall respect the enrollee’s request to continue treatment with the terminated provider.

**Providing The Enrollees With Notice Of The Provider Agreement Termination**

To protect enrollees’ continuity of care rights, the Knox-Keene Act is specific about the process to be followed in notifying enrollees about a provider contract termination.

**75 Day Notice Requirement.** Section 1373.65(a) addresses notice requirements imposed on Plans where there is a termination of a “provider group” and “block transfer” of enrollees:

At least 75 days prior to the termination date of its contract with a provider group the health care service plan shall submit an enrollee block transfer filing to the department that includes the written notice the plan proposes to send to affected enrollees. The plan may not send this notice to enrollees until the department has reviewed and approved its content. If the department does not respond within seven days of the date of its receipt of the filing, the notice shall be deemed approved.

A “provider group” is defined in subsection (g) as a “medical group, independent practice association or similar organization.” The use of the phrase “or similar organization” suggests that “provider group” refers to organizations that provide a function similar to that of an IPA, rather than a group that actually treats the enrollees. The inclusion of subsection (d) supports this conclusion by addressing the termination of a contract between an “individual provider” and a provider group, defining provider as an “organization” or “association” licensed to “deliver or furnish health care services;” i.e., the doctors treating the patients. H&S § 1345(i). The notice requirement in 1373.65(a) appears not to apply to contract terminations between Plans or IPAs and the “individual providers” who treat the patients. As “medical group” is included in the definition of “provider group,” the pre-filing requirement of Section 1373.65 appears to apply where individual providers come together to form a medical group as there are a larger number of enrollees potentially impacted by the termination justifying a pre-filing plan for approval by the DMHC.

Even if there is a termination of a “provider group,” Section 1373.65’s
60-Day Notice Requirement. Even if the 75 day notice requirement of Section 1373.65(a) does not apply, notice still must be provided under the Knox-Keene Act relating to provider contract terminations. Section 1373.65(b) (applicable to terminations between Plans and provider groups) and Section 1373.65(d) (applicable to terminations between Plans and individual providers) mandate that, at least 60 days prior to the contract termination date, the Plan shall send the notice described in Section 1373.65(a) by mail to enrollees who are assigned to the terminated provider group. The notice described in subsection (a) cannot be sent until the department has “reviewed and approved” its content.

Contents Of Any Notice. Any notice of termination mailed to an enrollee must include, among other things, (a) “A brief explanation of why the transfer is necessary due to the termination of the contract between the plan and the Terminated Provider,” (b) "the date of the pending contract termination and transfer," and, (c) an explanation regarding the process for assignment to a new provider group, including notice that the patient may select a different network provider "as outlined in the plan's written continuity of care policy." 28 CCR § 1300.67.1.3. The notice must also include:

A statement that the Affected Enrollee may contact the plan’s customer service department to request completion of care for an ongoing course of treatment from a Terminated Provider. This statement may include either a statement outlining the specific conditions set forth in California Health and Safety Code section 1373.96(c), or an explanation to the Affected Enrollee that his or her eligibility is conditioned upon certain factors as outlined in the plan’s written continuity of care policy and evidence of coverage or disclosure form.

28 CCR § 1300.67.1.3.

Significantly, the notice must include, in at least 8-point font, the following verbatim statement: “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.” Health & Safety §1373.65(f).” This language must be included regardless of whether the communication comes from the Plan or the terminated provider. Health & Safety Code §1373.65(f).

Conclusion

Understanding the DMHC submission and notice requirements imposed on a Plan in connection with its termination of a provider agreement places the provider in a better position to understand whether the Plan is acting consistent with the enrollees’ continuity of care rights and, importantly, whether the enrollee has the right to continue receiving care and treatment from the terminated provider. If the Plan is interfering with the physician-patient relationship by not complying with the submission requirements, or providing inaccurate or flawed notice to the enrollees, the terminated provider has the ability to preserve the physician-patient relationship by reporting the violations, sending out its own compliant communication to the enrollee, and/or bringing legal action.

1All references are to the California Health and Safety Code unless otherwise indicated.

2This is not to suggest that additional licensing is required for IPAs.

3An acute condition is defined in Section 1373.96(c) (1) as “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.”

4A terminal illness is defined in Section 1373.96(c)(2) as “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 a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.”

5A serious chronic condition is defined in Section 1373.96(c)(2) as “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.”