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Policy Name TRANSITION TO OR FROM A GROUP BENEFIT PLAN SERVICED BY BEHAVIORAL HEALTH	Policy Number HM-CLN-037
Business Segment Behavioral Health	
Initial Effective Date: 06/25/96	**Policy Committee Approval Date(s):** 3/23/21; 9/28/21; 11/16/21; 12/14/21; 7/26/22; 7/11/23; 6/11/24; 12/10/24
Replaces Policies: N/A	

Purpose:
To provide a process for an orderly, contractually and clinically appropriate transition when Behavioral Health or prospective customers change benefit plans.

Policy Statement:
Behavioral Health's staff and consultants shall provide transition for customers receiving clinical services at the time they change benefit plans to or from Behavioral Health in such a way that the change will produce the least problems to the customers and be consistent with the contracts Behavioral Health has or has had with the contracting entities and state laws. The standard transition benefit affords the member up to 90 days after the effective date of the contract to contact Behavioral Health to access transition benefits. If approved, claims will be covered at the in-network level for 90 days. All requests need to be received within decision timeframes.

Definitions:
For purposes of this policy "customer" means an individual participant or member.

State/Federal Compliance: Please refer to Appendix A for State Specific transition of care requirements.

Procedure(s):

A. Customers in a transitioning client/group will become the financial responsibility of the benefit plan in effect at the time of transition unless otherwise provided for by contract or state law or when an ASO plan has elected an extension of benefits.
B. At the time of transition, Behavioral Health shall provide and/or request a report containing:
    1. Customer name
    2. Social Security Number
    3. Facility Name/Location
    4. UR Name/Phone Number
    5. Anything else pertinent to the agreement

Note: This may exclude some PPO carve in business where data extraction is restricted or limited due to the structure of the account or product.

C. Behavioral Health shall make transition decisions for customers in routine outpatient treatment with the organization on the effective day of coverage based on the customer's clinical needs, available coverage and the following:
    1. For Health Plan HMO and Network Product Business:
        a. If the treating practitioner is not in Behavioral Health's practitioner network, based on the treatment summary and goals up to 30 days may be authorized for the current practitioner to complete treatment and/or prepare the customer for transition to a Behavioral Health network practitioner. The member has up to 90 days after the effective date of the contract to contact Behavioral Health to access transition benefits and claims will be covered at the in-network level for 30 days.
        b. If the severity of the customer's condition requires continuing treatment beyond 30 days, Behavioral Health may continue to authorize care at in-network benefit levels based on the treating provider's request and clinical review.
    2. For Employer Product Business
        a. Transition benefits are at the discretion of the employer.
    3. For PPO/OAP Business
        a. If the employer has recently introduced a Cigna Healthcare plan as a new option during the customer's open enrollment period, the customer or practitioner is not required to submit a Transition of Care Request form – claims will be automatically processed at in-network benefit levels for 90 days from the policy effective date. If TOC forms are received, transition benefit authorizations will be written as a form of acknowledgement to the customer and provider.
        b. If the customer is a new hire or has recently selected the Cigna Healthcare option already offered by his/her employer, the customer is required to complete the Transition of Care form and submit it following the directions on the TOC form. Transition benefit authorizations will be written and letters will be sent to the customer and to the provider for the transition period.
    4. For Health Plan, HMO, Network, PPO/OAP and Employer Product business
        a. It is the Customer's responsibility to contact Behavioral Health for transition benefits, if required.
        b. If care beyond the contracted transition period is requested, and the treating practitioner is not in Behavioral Health's practitioner network, a clinical review will be conducted with the treating provider to assess medical necessity and network adequacy. Further authorization using in-network benefits may be considered with the necessary information. If authorization is approved, Behavioral Health shall attempt to negotiate an ad hoc agreement with the treating practitioner pursuant to the confidentiality policy and procedure, including payment at the Behavioral Health's in-network rate.
        c. If a network practitioner appropriate to the customer's clinical needs is not available within the service area of the participant, Behavioral Health may continue to authorize care at in-network benefit levels.
        d. If a non-network practitioner and/or customer does not agree with Behavioral Health's transition recommendations, the practitioner or customer have access to the peer-to-peer review and complaint processes. The customer may also choose to use out-of-network benefits, if available.

e. If the treating practitioner is a Behavioral Health network practitioner and the services are a covered benefit, transition benefits would not be applicable, and care would be approved consistent with Behavioral Health's policy and procedure on clinical review and the Behavioral Health utilization management guidelines.

D. Non-routine outpatient services such as applied behavior analysis and transcranial magnetic stimulation will be subject to medical necessity review to determine the appropriateness of a transition of care.

COMPLIANCE MEASURE(S):
Compliance with this policy can be measured through a review and analysis of customer complaints and appeals.

Applicable Enterprise Privacy Policies:
https://iris.cigna.com/business_units/legal_department/enterprise_compliance/privacy/privacy_policies

Related Policies and Procedures:
IFP-52 Network Provider Directory (TOC/COC/NAP/Exception)
HM-CLN-018 Continuity and Coordination of Behavioral Care

Links/PDFs: N/A

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APPENDIX A – STATE SPECIFIC TRANSITION OF CARE REQUIREMENTS

ARIZONA
ARS 20-1057.04

A. **CONDITIONS THAT WARRANT EXTENDED COVERAGE**
   1. HMO plans
   2. Continued or transitional care provisions will be extended to members who are undergoing treatment with their current disaffiliated or non-participating provider for either a life threatening disease or condition or third trimester pregnancy care.

B. **LENGTH OF EXTENDED COVERAGE**
   1. Minimum transition period for both Continuity of Care and Transition of Care is as follows:
      a. Thirty (30) days for a life threatening condition
      b. From the third trimester of pregnancy up to six weeks after delivery

ARKANSAS
AR Code 23-99-408

A. Behavioral provides Transition of Care services at the initial enrollment of a group to facilitate transition of medical or behavioral health care for members from non-participating to participating providers. A newly eligible member may receive coverage for services provided by a non-participating provider for a defined period of time when approved by Behavioral.
B. Services that will be considered for approval are:
   1. Terminal conditions for members with less than 6 months to live;
   2. Acute or chronic conditions in active treatment, not to exceed 60 days for HMO/POS and Open Access participants (Note:HMO's must provide this for 90 days in Arkansas) and 90 days for PPO participants, although these timeframes may be extended if medically necessary or if state law requires a longer period of transition of care;
   3. Active engagement in a rehabilitation program (physical, occupational and speech therapy and chiropractic care) for a condition with a new onset within the 21 days preceding eligibility, subject to the benefit plan's therapy limitation;
   4. Pregnancy in the second or third trimester through postpartum care (usually six weeks after delivery).
C. Despite the timeframes listed above, Transition of Care coverage will end when care for the acute condition or treatment is completed, care is successfully transitioned to a participating provider, the approved time period is exceeded, or benefit limitations are exceeded.

MAINE
24-A M.R.S. § 4303(7)

A. Transitional care provisions will be extended to enrollees who are engaged in an ongoing course of treatment with their provider and for enrollees who are in their 2nd trimester of pregnancy at the time of the provider's termination and the provider is treating the enrollee during pregnancy.

1. Coverage will continue for pregnant enrollees in their second trimester through delivery and postpartum.

MASSACHUSETTS
958 CMR 3.503

A. CONDITIONS THAT WARRANT EXTENDED COVERAGE
    1. A carrier shall provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a physician who is not a participating provider in the carrier's network pursuant to the conditions listed above.
        a. Pregnancy: Continued coverage of treatment for a period up to and including the insured's first postpartum visit.
        b. Terminally ill: Continued coverage of treatment until the insured's death.

MINNESOTA
62Q.56

A. Continued or transitional care must be authorized for members undergoing treatment for
    1. an acute condition,
    2. a disabling or chronic condition that is in an acute phase,
    3. any life-threatening mental or physical illness
    4. a physical or mental disability persisting for, or with an expected duration of, at least one year, or that can be expected to result in death;
    5. or pregnancy, if the member is in her first trimester at the time of provider termination or new enrollment.
B. Continued or transitional care must also be authorized in situations where the member is receiving culturally appropriate services from a terminated or non-participating provider or for a member who does not speak English, and there is no participating provider in the network who can satisfactorily accommodate either of these special needs.
C. Insurers must develop criteria that will be used to determine whether a need for continuity or transition of care exists based on diagnoses or special circumstances and how it will be provided.
D. Coverage must be extended to eligible members (see above) for a transitional period of up to 120 days.
    1. However, if a physician, advanced practice registered nurse, or physician assistant certifies that a member has a life expectancy of 180 days or less, uninterrupted coverage must be provided for the remainder of the member's life.

NEW HAMPSHIRE
Reg 1901.05 (e)/2201.11

A. An 'active recipient of mental health services' under a prior plan can continue receiving services from the same mental health provider who provided services under the prior plan for up to one year from the effective date of the new Cigna Behavioral Health plan.

B. An 'active recipient of mental health services' is defined by New Hampshire as: an insured, subscriber or member of a replacing carrier's plan who received mental health services from a mental health provider while covered under a prior carrier's plan, provided such services were received for a purpose other than monitoring medications and were received at least as often as:
    1. For outpatient services:
        a. For 2 separate days during the 30 day period immediately prior to the effective date of the replacing carrier's plan; or
        b. For 3 separate days during the 90 day period immediately prior to the effective date of the replacing carrier's plan; or
        c. For 5 separate days during the 12 month period immediately preceding the effective date of the replacing carrier's plan; and
    2. For inpatient services:
        a. One confinement during the 12 month period immediately prior to the effective date of the replacing carrier's plan.

NEW MEXICO
NMAC13.10.23.14

A. CONDITIONS THAT WARRANT EXTENDED COVERAGE
    1. In the event of a disaffiliation between a provider and the carrier (for reasons unrelated to medical competence or professional behavior), the carrier must permit the enrollee to continue an ongoing course of treatment for a transitional period of not less than 30 days and for a sufficient period to permit coordinated transition planning consistent with the patient's condition and needs relating to continuity of care.
    2. When the enrollee is in the third trimester of pregnancy, the transitional period shall continue through postpartum care directly related to the delivery.
B. LENGTH OF EXTENDED COVERAGE
    1. Coverage must be extended for a time that is sufficient to permit coordinated transition planning consistent with the patient's condition and needs relating to continuity of case and, in any event, shall not be less than a period of 30 days.
    2. If an enrollee has entered the third trimester of pregnancy at the time of the provider's disaffiliation or at the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery.

NEW YORK
Ins Law Section 4804

A. If a new insured/member's provider is not a member of the network, the carrier must allow the new insured/member to continue an ongoing course of treatment with that provider for up to 60 days from the effective date of enrollment, if:
    1. The individual has a life-threatening or degenerative and disabling disease or condition; or

2. The individual has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period will include the provision of post-partum care directly related to delivery.

B. Care will be authorized by the carrier during the transitional period only if the provider agrees to:
   1. Continue to accept reimbursement at the rates in place prior to the start of the transitional period as payment in full;
   2. Adhere to the carrier's quality assurance requirements and to provide necessary medical information related to the care; and
   3. Otherwise adhere to the carrier's policies and procedures, including, but not limited to, referrals, pre-authorizations and treatment plans approved by the carrier.

NORTH CAROLINA

58-67-88 SB 199 2001 session

A. CONDITIONS THAT WARRANT EXTENDED COVERAGE
   1. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
   2. In the case of a chronic illness or condition, a disease or condition that is life threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time
   3. In the case of pregnancy, pregnancy from the start of the second trimester.
   4. In the case of a terminal illness, a medical prognosis that individual's life expectancy is six months or less.

B. Generally, the transitional period shall be extended up to 90 days except for the following:
   1. Pregnancy- If insured entered second trimester on date of notice or date of enrollment in new plan, and provider was treating the pregnancy before the date of notice, transitional period shall extend through 60 days of post partum care.
   2. Terminal illness - If terminally ill (6 months or less to live) at time of provider's termination the transitional period shall extend for the remainder of the individual's life.

PENNSYLVANIA

28 PA ADC 9.684; 40 PS 991.2117; 31 PA ADC 154.15

A. Cigna Behavioral Health shall make transition decisions for participants in outpatient treatment with Cigna Behavioral Health on the effective day of coverage based on the participant’s clinical needs, available coverage and the following: 1. For Health Plan business: a. If the treating practitioner is not in Cigna Behavioral Health’s practitioner network, based on the treatment summary and goals:
   1. Up to 60 days may be authorized for the current practitioner to complete treatment and/or prepare the participant for transition to a Cigna Behavioral Health network practitioner.
   2. If the severity of the participant condition requires continuing treatment beyond 60 days, Cigna Behavioral Health may continue to authorize care at in-network benefit levels.

VERMONT

A. Behavioral Health shall permit certain new members to continue to use their previous providers, so long as those providers agree to abide by Behavioral Health's payment rates, quality-of-care standards and protocols, and to provide necessary clinical information.
B. New members with life-threatening, disabling, or degenerative conditions shall be allowed to continue to see their providers for sixty (60) days from the date of enrollment or until accepted by a new provider within Behavioral Health's network, whichever is shorter.
C. The medical director or his/her delegate may approve a request pertaining to an individual who identifies as possessing life-threatening, disabling, or degenerative conditions by using the definition of Life-threatening emergency as outlined in the Access to Care and Telephonic Standards policy and procedure and the following definition to define disabling or degenerative; a condition that requires specialized medical care over a period of time.
D. Behavioral Health shall instruct the member to have their current provider contact Behavioral Health via telephone to discuss the clinical information and transition process.
E. Should the medical director or his/her delegate,
    1. Believe that the member does not qualify a meeting the criteria for life-threatening, disabling, or degenerative conditions, or
    2. Find the provider to lack requisite education, training and experience with the member's condition,
    3. Then, Behavioral Health shall inform the member and the provider of the decision and of the right to grieve the decision through Behavioral Health's formal grievance process.
F. Behavioral Health shall provide members who are active patients with written notice within 15 days of receipt or issuance of termination without cause, or of the date of termination with cause. Active treatment is defined as having received care from the provider within the 90 days preceding the termination notification or having received at least two visits from with the provider within the last twelve months preceding termination notification.