1300.67.1.3 Block Transfer Filings

(a)

Definitions. As used in this section:(1) "Affected Enrollee" means enrollees of the plan who are assigned to a Terminated Provider Group or a Terminated Hospital. (2) "Alternate Hospital" means a hospital that will provide services to plan enrollees in place of a Terminated Hospital. (3) "Block Transfer" means a transfer or redirection of two thousand (2,000) or more enrollees by a plan from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract. (4) "Enrollee Transfer Notice" means a written notice that is sent to enrollees who are assigned to a Terminated Provider group or Terminated Hospital. (5) "Provider Contract" means a contract between a plan and one or more health care providers, through which the plan arranges to provide health care services for its enrollees. (6) "Provider Group" means a medical group, an independent practice association, or any other similar organization providing services to enrollees of a plan who are assigned to that provider group. (7) "Receiving Provider Group" means a provider group that will provide services to Affected Enrollees in place of the current Provider Group. (8) "Terminated Hospital" means a general acute care hospital that will no longer maintain a Provider Contract with the plan following the termination or non-renewal of a Provider Contract. (9) "Terminated Provider" means either a Terminated Provider

Group or a Terminated Hospital. (10) "Terminated Provider Group" means a Provider Group that will no longer maintain a Provider Contract with the plan following the termination or non-renewal of a Provider Contract.

(1)

"Affected Enrollee" means enrollees of the plan who are assigned to a Terminated Provider Group or a Terminated Hospital.

(2)

"Alternate Hospital" means a hospital that will provide services to plan enrollees in place of a Terminated Hospital.

(3)

"Block Transfer" means a transfer or redirection of two thousand (2,000) or more enrollees by a plan from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract.

(4)

"Enrollee Transfer Notice" means a written notice that is sent to enrollees who are assigned to a Terminated Provider group or Terminated Hospital.

(5)

"Provider Contract" means a contract between a plan and one or more health care providers, through which the plan arranges to provide health care services for its enrollees.

(6)

"Provider Group" means a medical group, an independent practice association, or any other similar organization providing services to enrollees of a plan who are assigned to that provider group.

(7)

"Receiving Provider Group" means a provider group that will provide services to Affected Enrollees in place of the current Provider Group.

(8)

"Terminated Hospital" means a general acute care hospital that will no longer maintain a Provider Contract with the plan following the termination or non-renewal of a Provider Contract.

(9)

"Terminated Provider" means either a Terminated Provider Group or a Terminated Hospital.

(10)

"Terminated Provider Group" means a Provider Group that will no longer maintain a Provider Contract with the plan following the termination or non-renewal of a Provider Contract.

(b)

For any proposed Block Transfer, a plan shall file with the Department a Block Transfer filing that includes, at minimum, all the items of information described in this subsection (b). The Block Transfer filing must be submitted to the Department at least seventy-five (75) days prior to the termination or non-renewal of any Provider Contract with a Terminated Provider Group or a Terminated Hospital. The Block Transfer filing must be submitted in an electronic format developed by the Department and made available at the Department's website at www.hmohelp.ca.gov and must include, at minimum, all of the following information as appropriate for the type of provider involved: (1) A form of the written notice that the plan intends to send to Affected Enrollees. The Enrollee Transfer Notice must include: (A) The name of the Terminated Provider Group or Terminated Hospital. The plan may also add the name of the assigned physician,

where appropriate. (B) A brief explanation of why the transfer is necessary due to the termination of the contract between the plan and the Terminated Provider. (C) The date of the pending contract termination and transfer. (D) An explanation to the Affected Enrollee outlining the Affected Enrollee's assignment to a new Provider Group, options for selecting a physician within a new Provider Group, and applicable timeframes to make a new Provider Group selection. The explanation must include a notification to the Affected Enrollee that he or she may select a different network provider by contacting the plan as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form. (E) A statement that the plan will send the Affected Enrollee a new member information card with the name, address and telephone number of the Receiving Provider Group and assigned physician by a specified later date, which will occur prior to the date of the contract termination. Alternatively, the plan may notify the Affected Enrollee of the name, address and telephone number of the new Provider Group and assigned physician, or Alternate Hospital, to which the Affected Enrollee will be assigned in the absence of a selection made by the enrollee. (F) 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. (G) The telephone number through which the Affected Enrollee may contact the plan for a further explanation of his or her rights to completion of care, including the plan's written continuity of care policy; and a link that an Affected Enrollee may use to

obtain of a downloadable copy of the policy from the plan's website. (H) A statement informing any enrollee of a point of service product that the Affected Enrollee may be required to pay a larger portion of costs if he or she continues to use his or her current providers, if applicable to the particular Block Transfer. (I) The following statement in at least 8-point font: "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." The statement may be modified to include the health care service plan's name in place of the phrase "your HMO's." (J) The plan shall require all contracted providers to include the statutory language required by California Health and Safety Code section 1373.65(f) in all communications to Affected Enrollees that concern the termination of a provider or a Block Transfer. (K) Compliance with all applicable language assistance statues and regulations, including Section 1367.04 and any regulations based upon Section 1367.04. (2) For a Terminated Hospital contract the plan shall also submit the following information: (A) A brief explanation of the cause of the hospital redirection including whether the contract termination or non-renewal was initiated by the plan, the hospital, or by a contracting Provider Group. (B) A copy of the notice of termination sent or received by the plan. (C) If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care. (D) Either of the following two options: 1. a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each

county, or 2. a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code. (E) The number of Affected Enrollees assigned to the Terminated Hospital, and the number to be reassigned to each Alternate Hospital, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.) (F) The number of Affected Enrollees within a 15-mile radius of the Terminated Hospital. (G) The date that the plan anticipates it will mail the Enrollee Transfer Notification. (H) The proposed date or dates of transfer of Affected Enrollees. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates. (I) If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, provide copies of each proposed notice as well as an explanation of the status of each required approval. (J) The identity of the Terminated Hospital and Alternate Hospital including the contract renewal or termination date for each Alternate Hospital. (K) A listing identifying any services that are available at the Terminated Hospital that are not available at an Alternate Hospital. The plan must discuss the arrangements it has made to ensure that enrollees have an opportunity to receive those services. (L) Based upon the data made public on the Office of Statewide Health Planning and Development's website, for each of the proposed Alternate Hospitals, provide the available bed occupancy rate for the most recently completed calendar year. If the rate is at 80% or higher, please provide justification as to the sufficiency of the Alternate Hospital's capacity to serve additional plan enrollees. (M) The number of bed days utilized by plan enrollees at the Terminated Hospital for the most recently completed calendar year. (N) An analysis showing the driving distance between the proposed Alternate Hospital and the Terminated Hospital. (O) Of the primary care providers to whom Affected enrollees are currently assigned, the

number and percentage of primary care providers with active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary care providers and the number and percentage of primary care providers without active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary care providers. (P) Explain the procedure by which an Affected Enrollee who is assigned to a primary care provider who does not have active admitting privileges to the Alternate Hospital(s) will receive needed hospital care. (Q) Of the specialists available to Affected Enrollees with active admitting privileges at the Terminated Hospital, the number and percentage with active admitting privileges at the Alternate Hospital(s). If any of these specialists will be unable to admit to the Alternate Hospital(s), disclose the specialty involved, how many specialists of that specialty, if any, will still be available to admit the Alternate Hospital(s) and explain how Affected Enrollees will receive care for that specialty at a proposed Alternate Hospital if there are an insufficient number of remaining specialists with active admitting privileges. (R) A disclosure of any anticipated increase in costs that will be incurred by Affected Enrollees of the plan's point of service products resulting from termination of the current hospital's contract if they continue to use the Terminated Provider. (S) Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees. (3) For a Provider Group contract termination, the plan shall also submit the following information: (A) A brief explanation of the cause or circumstances of the Provider Contract termination or non-renewal, including whether the contract termination or non-renewal was initiated by the plan or the Provider Group. If the Provider Contract termination is due to a provider closure, specify whether the provider closure is due to a bankruptcy, an insolvency, a sale, ceasing business operations

or the closure of a specific office site. (B) A copy of the notice of termination sent or received by the plan. (C) If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care. (D) Either of the following two options:(i) a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or (ii) a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code. (E) A listing, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.) that specifies the number of Affected Enrollees assigned to the Terminated Provider. (F) The date that the plan anticipates it will mail the Enrollee Transfer Notice. (G) The proposed date or dates of transfer. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates. (H) The plan's estimate of the percentage of Affected Enrollees who will remain with the same primary care provider after the transfer to a Receiving Provider Group. (I) If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, please provide copies of each proposed notice as well as an explanation of the status of each required approval. (J) A matrix of proposed Receiving Provider Groups that includes the following information: 1. the identity of the Receiving Provider Group(s), including its Risk Bearing Organization (RBO) number as assigned by the Department, 2. the number of Affected Enrollees being transferred to each Receiving Provider Group listed by type of product. If the plan gives the Affected Enrollees the choice of selecting a new provider, then the plan must provide the number of Affected Enrollees to be transferred to each receiving Provider Group by default if no selections are made by the Affected Enrollees, 3. a listing of all hospitals to which Receiving Provider Groups refer Affected Enrollees, if different

from the Terminated Provider Group. (K) Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(1)

A form of the written notice that the plan intends to send to Affected Enrollees. The Enrollee Transfer Notice must include: (A) The name of the Terminated Provider Group or Terminated Hospital. The plan may also add the name of the assigned physician, where appropriate. (B) A brief explanation of why the transfer is necessary due to the termination of the contract between the plan and the Terminated Provider. (C) The date of the pending contract termination and transfer. (D) An explanation to the Affected Enrollee outlining the Affected Enrollee's assignment to a new Provider Group, options for selecting a physician within a new Provider Group, and applicable timeframes to make a new Provider Group selection. The explanation must include a notification to the Affected Enrollee that he or she may select a different network provider by contacting the plan as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form. (E) A statement that the plan will send the Affected Enrollee a new member information card with the name, address and telephone number of the Receiving Provider Group and assigned physician by a specified later date, which will occur prior to the date of the contract termination. Alternatively, the plan may notify the Affected Enrollee of the name, address and telephone number of the new Provider Group and assigned physician, or Alternate Hospital, to which the Affected Enrollee will be assigned in the absence of a selection made by the enrollee. (F) 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. (G) The telephone number through which the Affected Enrollee may contact the plan for a further explanation of his or her rights to completion of care, including the plan's written continuity of care policy; and a link that an Affected Enrollee may use to obtain of a downloadable copy of the policy from the plan's website. (H) A statement informing any enrollee of a point of service product that the Affected Enrollee may be required to pay a larger portion of costs if he or she continues to use his or her current providers, if applicable to the particular Block Transfer. (I) The following statement in at least 8-point font: "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." The statement may be modified to include the health care service plan's name in place of the phrase "your HMO's." (J) The plan shall require all contracted providers to include the statutory language required by California Health and Safety Code section 1373.65(f) in all communications to Affected Enrollees that concern the termination of a provider or a Block Transfer. (K) Compliance with all applicable language assistance statues and regulations, including Section 1367.04 and any regulations based upon Section 1367.04.

(A)

The name of the Terminated Provider Group or Terminated Hospital. The plan may also add the name of the assigned physician, where appropriate.

(B)

A brief explanation of why the transfer is necessary due to the termination of the contract between the plan and the Terminated Provider.

(C)

The date of the pending contract termination and transfer.

(D)

An explanation to the Affected Enrollee outlining the Affected Enrollee's assignment to a new Provider Group, options for selecting a physician within a new Provider Group, and applicable timeframes to make a new Provider Group selection. The explanation must include a notification to the Affected Enrollee that he or she may select a different network provider by contacting the plan as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form.

(E)

A statement that the plan will send the Affected Enrollee a new member information card with the name, address and telephone number of the Receiving Provider Group and assigned physician by a specified later date, which will occur prior to the date of the contract termination. Alternatively, the plan may notify the Affected Enrollee of the name, address and telephone number of the new Provider Group and assigned physician, or Alternate Hospital, to which the Affected Enrollee will be assigned in the absence of a selection made by the enrollee.

(F)

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.

(G)

The telephone number through which the Affected Enrollee may contact the plan for a further explanation of his or her rights to completion of care, including the plan's written continuity of care policy; and a link that an Affected Enrollee may use to obtain of a downloadable copy of the policy from the plan's website.

(H)

A statement informing any enrollee of a point of service product that the Affected Enrollee may be required to pay a larger portion of costs if he or she continues to use his or her current providers, if applicable to the particular Block Transfer.

(I)

The following statement in at least 8-point font: "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." The statement may be modified to include the health care service plan's name in place of the phrase "your HMO's."

(J)

The plan shall require all contracted providers to include the statutory language required by California Health and Safety Code section 1373.65(f) in all communications to Affected Enrollees that concern the termination of a provider or a Block Transfer.

(K)

Compliance with all applicable language assistance statues and regulations, including Section 1367.04 and any regulations based upon Section 1367.04.

(2)

For a Terminated Hospital contract the plan shall also submit the following information: (A) A brief explanation of the cause of the hospital redirection including whether the contract termination or non-renewal was initiated by the plan, the hospital, or by a contracting Provider Group. (B) A copy of the notice of termination sent or received by the plan. (C) If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care. (D) Either of the following two options: 1. a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or 2. a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code. (E) The number of Affected Enrollees assigned to the Terminated Hospital, and the number to be reassigned to each Alternate Hospital, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.) (F) The number of Affected Enrollees within a 15-mile radius of the Terminated Hospital. (G) The date that the plan anticipates it will mail the Enrollee Transfer Notification. (H) The proposed date or dates of transfer of Affected Enrollees. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates. (I) If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, provide copies of each proposed notice as well as an explanation of the status of each required approval. (J) The identity of the Terminated Hospital and Alternate Hospital including the contract renewal or termination date for each Alternate Hospital. (K) A listing identifying any services that are available at the Terminated Hospital that are not available at an Alternate Hospital. The plan must discuss the arrangements it has made to ensure that enrollees have an opportunity to receive those services. (L) Based upon the data made public on the Office of Statewide Health Planning and Development's website, for each of the proposed Alternate Hospitals,

provide the available bed occupancy rate for the most recently completed calendar year. If the rate is at 80% or higher, please provide justification as to the sufficiency of the Alternate Hospital's capacity to serve additional plan enrollees. (M) The number of bed days utilized by plan enrollees at the Terminated Hospital for the most recently completed calendar year. (N) An analysis showing the driving distance between the proposed Alternate Hospital and the Terminated Hospital. (O) Of the primary care providers to whom Affected enrollees are currently assigned, the number and percentage of primary care providers with active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary care providers and the number and percentage of primary care providers without active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary care providers. (P) Explain the procedure by which an Affected Enrollee who is assigned to a primary care provider who does not have active admitting privileges to the Alternate Hospital(s) will receive needed hospital care. (Q) Of the specialists available to Affected Enrollees with active admitting privileges at the Terminated Hospital, the number and percentage with active admitting privileges at the Alternate Hospital(s). If any of these specialists will be unable to admit to the Alternate Hospital(s), disclose the specialty involved, how many specialists of that specialty, if any, will still be available to admit the Alternate Hospital(s) and explain how Affected Enrollees will receive care for that specialty at a proposed Alternate Hospital if there are an insufficient number of remaining specialists with active admitting privileges. (R) A disclosure of any anticipated increase in costs that will be incurred by Affected Enrollees of the plan's point of service products resulting from termination of the current hospital's contract if they continue to use the Terminated Provider. (S) Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(A)

A brief explanation of the cause of the hospital redirection including whether the contract termination or non-renewal was initiated by the plan, the hospital, or by a contracting Provider Group.

(B)

A copy of the notice of termination sent or received by the plan.

(C)

If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care.

(D)

Either of the following two options: 1. a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or 2. a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code.

1.

a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or

2.

a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code.

(E)

The number of Affected Enrollees assigned to the Terminated Hospital, and the number to be reassigned to each Alternate Hospital, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.)

(F)

The number of Affected Enrollees within a 15-mile radius of the Terminated Hospital.

(G)

The date that the plan anticipates it will mail the Enrollee Transfer Notification.

(H)

The proposed date or dates of transfer of Affected Enrollees. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates.

(I)

If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, provide copies of each proposed notice as well as an explanation of the status of each required approval.

(J)

The identity of the Terminated Hospital and Alternate Hospital including the contract renewal or termination date for each Alternate Hospital.

(K)

A listing identifying any services that are available at the Terminated Hospital that are not available at an Alternate Hospital. The plan must discuss the arrangements it has made to ensure that enrollees have an opportunity to receive those services.

(L)

Based upon the data made public on the Office of Statewide Health Planning and Development's website, for each of the proposed Alternate Hospitals, provide the available bed occupancy rate for the most recently completed calendar year. If the rate is at 80% or higher, please provide justification as to the sufficiency of the Alternate Hospital's capacity to serve additional plan enrollees.

(M)

The number of bed days utilized by plan enrollees at the Terminated Hospital for the most recently completed calendar year.

(N)

An analysis showing the driving distance between the proposed Alternate Hospital and the Terminated Hospital.

(O)

Of the primary care providers to whom Affected enrollees are currently assigned, the number and percentage of primary care providers with active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary care providers and the number and percentage of primary care providers without active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary care providers.

(P)

Explain the procedure by which an Affected Enrollee who is assigned to a primary care provider who does not have active admitting privileges to the Alternate Hospital(s) will receive needed hospital care.

(Q)

Of the specialists available to Affected Enrollees with active admitting privileges at the Terminated Hospital, the number and percentage with active admitting privileges at the Alternate Hospital(s). If any of these specialists will be unable to admit to the Alternate Hospital(s), disclose the specialty involved, how many specialists of that specialty, if any, will still be available to admit the Alternate Hospital(s) and explain how Affected Enrollees will receive care for that specialty at a proposed Alternate Hospital if there are an insufficient number of remaining specialists with active admitting privileges.

(R)

A disclosure of any anticipated increase in costs that will be incurred by Affected Enrollees of the plan's point of service products resulting from termination of the current hospital's contract if they continue to use the Terminated Provider.

(S)

Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(3)

For a Provider Group contract termination, the plan shall also submit the following information: (A) A brief explanation of the cause or circumstances of the Provider Contract termination or non-renewal, including whether the contract termination or non-renewal was initiated by the plan or the Provider Group. If the Provider Contract termination is due to a provider closure, specify whether the provider closure is due to a bankruptcy, an insolvency, a sale, ceasing business operations or the closure of a specific office site. (B) A copy of the notice of termination sent or received by the plan. (C) If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care. (D) Either of the following two options:(i) a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or (ii) a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code. (E) A listing, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.) that specifies the number of Affected Enrollees assigned to the Terminated Provider. (F) The date that the plan anticipates it will mail the Enrollee Transfer Notice. (G) The proposed date or dates of transfer. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates. (H) The plan's estimate of the percentage of Affected Enrollees who will remain with the same primary care provider after the transfer to a Receiving Provider Group. (I) If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, please provide copies of each proposed notice as well as an explanation of the status

of each required approval. (J) A matrix of proposed Receiving Provider Groups that includes the following information: 1. the identity of the Receiving Provider Group(s), including its Risk Bearing Organization (RBO) number as assigned by the Department, 2. the number of Affected Enrollees being transferred to each Receiving Provider Group listed by type of product. If the plan gives the Affected Enrollees the choice of selecting a new provider, then the plan must provide the number of Affected Enrollees to be transferred to each receiving Provider Group by default if no selections are made by the Affected Enrollees, 3. a listing of all hospitals to which Receiving Provider Groups refer Affected Enrollees, if different from the Terminated Provider Group. (K) Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(A)

A brief explanation of the cause or circumstances of the Provider Contract termination or non-renewal, including whether the contract termination or non-renewal was initiated by the plan or the Provider Group. If the Provider Contract termination is due to a provider closure, specify whether the provider closure is due to a bankruptcy, an insolvency, a sale, ceasing business operations or the closure of a specific office site.

(B)

A copy of the notice of termination sent or received by the plan.

(C)

If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care.

(D)

Either of the following two options:(i) a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or (ii) a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for

each zip code.

(i)

a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or

(ii)

a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code.

(E)

A listing, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.) that specifies the number of Affected Enrollees assigned to the Terminated Provider.

(F)

The date that the plan anticipates it will mail the Enrollee Transfer Notice.

(G)

The proposed date or dates of transfer. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates.

(H)

The plan's estimate of the percentage of Affected Enrollees who will remain with the same primary care provider after the transfer to a Receiving Provider Group.

(I)

If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, please provide copies of each proposed notice as well as an explanation of the status of each required approval.

(J)

A matrix of proposed Receiving Provider Groups that includes the following information: 1. the identity of the Receiving Provider Group(s), including its Risk Bearing Organization (RBO) number as assigned by the Department, 2. the number of Affected Enrollees being

transferred to each Receiving Provider Group listed by type of product. If the plan gives the Affected Enrollees the choice of selecting a new provider, then the plan must provide the number of Affected Enrollees to be transferred to each receiving Provider Group by default if no selections are made by the Affected Enrollees, 3. a listing of all hospitals to which Receiving Provider Groups refer Affected Enrollees, if different from the Terminated Provider Group.

1.

the identity of the Receiving Provider Group(s), including its Risk Bearing Organization (RBO) number as assigned by the Department,

2.

the number of Affected Enrollees being transferred to each Receiving Provider Group listed by type of product. If the plan gives the Affected Enrollees the choice of selecting a new provider, then the plan must provide the number of Affected Enrollees to be transferred to each receiving Provider Group by default if no selections are made by the Affected Enrollees,

3.

a listing of all hospitals to which Receiving Provider Groups refer Affected Enrollees, if different from the Terminated Provider Group.

(K)

Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(c)

Timing of Notice Requirements. For any termination or non-renewal of a Provider Contract, a plan shall mail to all Affected Enrollees an Enrollee Transfer Notice that has been approved by the Department.(1) The Enrollee Transfer Notice must be mailed to each Affected Enrollee at least sixty (60) days prior to the date of termination or non-renewal.

(1)

The Enrollee Transfer Notice must be mailed to each Affected Enrollee at least sixty (60) days prior to the date of termination or non-renewal.

(d)

Notice Mailing Requirements. The plan shall send an Enrollee Transfer Notice to Affected Enrollees as follows: (1) For Affected Enrollees enrollees who are Block Transferred from a Terminated Provider Group -- the plan shall send the notice to all Affected Enrollees assigned to the Terminated Provider Group. (2) For Affected Enrollees who are block transferred from a Terminated Hospital -- the plan shall send the notice to all Affected Enrollees who reside within 15 miles of the Terminated Hospital.

(1)

For Affected Enrollees enrollees who are Block Transferred from a Terminated Provider Group -- the plan shall send the notice to all Affected Enrollees assigned to the Terminated Provider Group.

(2)

For Affected Enrollees who are block transferred from a Terminated Hospital -- the plan shall send the notice to all Affected Enrollees who reside within 15 miles of the Terminated Hospital.

(e)

If, for any reason, a plan is unable to send all Enrollee Transfer Notice required pursuant to subsection 1300.67.1.3(c) of Title 28, California Code of Regulations, at least sixty (60) days prior to the termination or non-renewal of a Provider Contract, the plan shall submit to the Department an application for a waiver of the 60-day requirement. The application for waiver must include an explanation of the plan's reasons for being unable to meet the 60-day notice

requirement and its proposal to minimize any disruption that may be caused to Affected Enrollees by the reduced notice. A waiver application may be based upon the sudden closure of a contracted provider, a notice-timing conflict with another jurisdictional agency, or other circumstances for which good-cause exists. If the Department does not approve or disapprove the waiver request within seven (7) days of its receipt of the request, the waiver will be deemed to have been approved by the Department.

(f)

If, after sending Enrollee Transfer Notices a plan reaches an agreement to renew or enter into a new Provider Contract or to not terminate their Provider Contract with a Terminated Provider to which the plan had assigned enrollees, then the plan shall promptly inform the Department and convey an additional enrollee notification, either by telephone or in writing, to each Affected Enrollee. The additional enrollee notification must include: (1) A brief explanation of the fact that the plan has reached an agreement with the Affected Enrollee's previously assigned provider. (2) An explanation to the enrollee regarding options for either returning to the previously assigned provider, keeping the newly assigned provider, or select another participating provider from the plan's contracting provider list. (3) An explanation to the Affected Enrollee of the procedure by which the enrollee may contact the plan to express his or her desire to return to the previously assigned provider. (4) If the additional enrollee notice is given in writing, then the notice must include the following statement in at least 8-point font: "If you have any questions regarding this notice please contact [Plan Name] customer service department. If you have further concerns about your provider network, you are encouraged to contact the Department of Managed Health Care by telephone at its toll-free number 1-888-HMO-2219, or at TDD number for the

hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov." (5) Compliance with all applicable language assistance statutes and regulations, including Section 1367.04 and any regulations based upon Section 1367.04.

(1)

A brief explanation of the fact that the plan has reached an agreement with the Affected Enrollee's previously assigned provider.

(2)

An explanation to the enrollee regarding options for either returning to the previously assigned provider, keeping the newly assigned provider, or select another participating provider from the plan's contracting provider list.

(3)

An explanation to the Affected Enrollee of the procedure by which the enrollee may contact the plan to express his or her desire to return to the previously assigned provider.

(4)

If the additional enrollee notice is given in writing, then the notice must include the following statement in at least 8-point font: "If you have any questions regarding this notice please contact [Plan Name] customer service department. If you have further concerns about your provider network, you are encouraged to contact the Department of Managed Health Care by telephone at its toll-free number 1-888-HMO-2219, or at TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

(5)

Compliance with all applicable language assistance statutes and regulations, including Section 1367.04 and any regulations based upon Section 1367.04.