Transition of Care/Transition of Services

The purpose of this policy is to provide guidance to Managed Care Organizations (MCOs) regarding HFS' requirements for transition of care and services, established pursuant to 215 ILCS 134/25.

A. A health care plan shall provide for continuity of care for its enrollees as follows.
   1) If an enrollee's health care provider leaves the health care plan's network of health care providers for reasons other than termination of a contract in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board and the provider remains within the health care plan's service area, or if benefits provided under such health care plan with respect to such provider are terminated because of a change in the terms of the participation of such provider in such plan, or if a contract between a group health plan, as defined in Section 5 of the Illinois Health Insurance Portability and Accountability Act, and a health care plan offered in connection with the group health plan is terminated and results in a loss of benefits provided under such plan with respect to such provider, the health care plan shall permit the enrollee to continue an ongoing course of treatment with that provider during a transitional period:
      a. of 90 days from the date of the notice of provider's termination from the health care plan to the enrollee of the provider's disaffiliation from the health care plan if the enrollee has an ongoing course of treatment; or
      b. if the enrollee has entered the third trimester of pregnancy at the time of the provider's disaffiliation, that includes the provision of post-partum care directly related to the delivery.
   2) Notwithstanding the provisions in item (1) of this subsection, such care shall be authorized by the health care plan during the transitional period only if the provider agrees:
      a. to continue to accept reimbursement from the health care plan at the rates applicable prior to the start of the transitional period;
      b. to adhere to the health care plan's quality assurance requirements and to provide to the health care plan necessary medical information related to such care; and
      c. to otherwise adhere to the health care plan's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorizations for treatment.
   3) During an enrollee's plan year, a health care plan shall not remove a drug from its formulary or negatively change its preferred or cost-tier sharing unless, at least 60 days before making the formulary change, the health care plan:
      a. provides general notification of the change in its formulary to current and prospective enrollees;
      b. directly notifies enrollees currently receiving coverage for the drug, including information on the specific drugs involved and the steps they may take to request coverage determinations and exceptions, including a statement that a certification of medical necessity by the enrollee's prescribing provider will result in continuation of coverage at the existing level; and
      c. directly notifies in writing through an electronic transmission the prescribing provider of all health care plan enrollees currently prescribed the drug affected by the proposed change; the notice shall include a one-page form by which the prescribing provider can

notify the health care plan in writing or electronically that coverage of the drug for the enrollee is medically necessary.

The notification in paragraph (C) may direct the prescribing provider to an electronic portal through which the prescribing provider may electronically file a certification to the health care plan that coverage of the drug for the enrollee is medically necessary. The prescribing provider may make a secure electronic signature beside the words "certification of medical necessity", and this certification shall authorize continuation of coverage for the drug.

If the prescribing provider certifies to the health care plan either in writing or electronically that the drug is medically necessary for the enrollee as provided in paragraph (C), a health care plan shall authorize coverage for the drug prescribed based solely on the prescribing provider's assertion that coverage is medically necessary, and the health care plan is prohibited from making modifications to the coverage related to the covered drug, including, but not limited to:

(i) increasing the out-of-pocket costs for the covered drug;
(ii) moving the covered drug to a more restrictive tier; or
(iii) denying an enrollee coverage of the drug for which the enrollee has been previously approved for coverage by the health care plan.

Nothing in this item (3) prevents a health care plan from removing a drug from its formulary or denying an enrollee coverage if the United States Food and Drug Administration has issued a statement about the drug that calls into question the clinical safety of the drug, the drug manufacturer has notified the United States Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the drug as required by Section 506C of the Federal Food, Drug, and Cosmetic Act, as codified in 21 U.S.C. 356c, or the drug manufacturer has removed the drug from the market.

Nothing in this item (3) prohibits a health care plan, by contract, written policy or procedure, or any other agreement or course of conduct, from requiring a pharmacist to effect substitutions of prescription drugs consistent with Section 19.5 of the Pharmacy Practice Act, under which a pharmacist may substitute an interchangeable biologic for a prescribed biologic product, and Section 25 of the Pharmacy Practice Act, under which a pharmacist may select a generic drug determined to be therapeutically equivalent by the United States Food and Drug Administration and in accordance with the Illinois Food, Drug and Cosmetic Act.
This item (3) applies to a policy or contract that is amended, delivered, issued, or renewed on or after January 1, 2019. This item (3) does not apply to a health plan as defined in the State Employees Group Insurance Act of 1971 or medical assistance under Article V of the Illinois Public Aid Code.

B. A health care plan shall provide for continuity of care for new enrollees as follows:
   1) If a new enrollee whose physician is not a member of the health care plan's provider network, but is within the health care plan's service area, enrolls in the health care plan, the health care plan shall permit the enrollee to continue an ongoing course of treatment with the enrollee's current physician during a transitional period:
      a. of 90 days from the effective date of enrollment if the enrollee has an ongoing course of treatment; or
      b. if the enrollee has entered the third trimester of pregnancy at the effective date of enrollment, that includes the provision of post-partum care directly related to the delivery.
   2) If an enrollee elects to continue to receive care from such physician pursuant to item (1) of this subsection, such care shall be authorized by the health care plan for the transitional period only if the physician agrees:
      a. to accept reimbursement from the health care plan at rates established by the health care plan; such rates shall be the level of reimbursement applicable to similar physicians within the health care plan for such services;
      b. to adhere to the health care plan's quality assurance requirements and to provide to the health care plan necessary medical information related to such care; and
      c. to otherwise adhere to the health care plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining preauthorization for treatment.

C. In no event shall this Section be construed to require a health care plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained in the enrollee's contract. In no event shall this Section be construed to prohibit the addition of prescription drugs to a health care plan's list of covered drugs during the coverage year.

In this Section, "ongoing course of treatment" has the meaning ascribed to that term in Section 5 of the Network Adequacy and Transparency Act.
(Source: P.A. 103-650, eff. 1-1-25.)

Bureau of Managed Care
Managed Care Organizations
Policy / Procedures

Policy History
General Contract Monitoring

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