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# Continuity of Care Service Requests

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## Scope

To ensure continuity of care and transition of customers who are in active treatment when their practitioner leaves the practitioner network or, in limited circumstances, when a client terminates its contract with Behavioral Health, and to adhere to federal regulations, state mandates, and/or Accreditation standards for continuity of care and transition of customers.

## General Background

- Continuity of care (COC) refers to the continuation of care for customers when
1. Any participating provider or facility leaves the network and ongoing care is requested.
  2. A fully insured client terminates their contract with Behavioral Health and the client’s replacement coverage does not include access to the health care professional at the in-network level and ongoing behavioral health care/services are requested

The Continuity of Care policy ensures continuity of care even if that behavioral health practitioner is a part of a group whose contract with the organization continues. Depending upon the requirements of each state, customers in active treatment will be given notification at least 30 calendar days prior to their participating practitioner’s contract termination effective date. In the

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rare case where a practitioner's contract terminates due to a reason which may be harmful to the customer, (such as breach of contract), death of the practitioner, or inability to locate the practitioner; Behavioral Health may notify customers within 15 days of termination decision date.

All customers will be appropriately transitioned to new practitioners based on the level of treatment and clinical needs at the time of termination. Customer notification and transition of care will require cooperation across departments in the organization.

\*Customers are notified of client terminations with Behavioral Health by their employer or plan sponsor.

## Definitions

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

**Continuity of Care (COC)** – Refers to the continuation of care for customers when any participating provider or facility leaves the network and ongoing care is requested.

**Transition of Care (TOC)** - Refers to the process of transitioning medical care for new enrollees from non-participating health care professionals to participating health care professionals.

## State/Federal Compliance

Some states may require a shorter notification timeline than Accreditation or CMS standards. Operating Units should be aware of state variances and adjust local policies to comply with state time frames as needed. Please refer to Appendix A for State Specific turnaround time requirements.

## Procedure

- A. notification for when a provider leaves the network:
  1. Establish Notification Timeline:
    - a. Behavioral Health will provide customers with 30 days notification that their practitioner's contract has terminated.
    - b. When a customer is being seen by a practitioner who is in breach of contract, dies or whom Behavioral Health is unable to locate and the termination is effective 'immediately' or 'within 30 days,' an exception to the 30-day customer notification could occur. In these instances, Behavioral Health can provide customer notification as soon as possible within 15 days.
    - c. Under the No Surprises Act, a customer has 90 days of COC available after receiving notice of provider termination. Calculation of the 90-day period should begin on the date notice of provider termination is provided and the customer has a full 90 days to request COC, although COC does not need to

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extend beyond 90 days from the date notice of provider termination is provided. Services eligible for COC are subject to benefit plan limitations and end when one of the following occurs:

- i. Care for the acute and/or chronic condition is completed.
- ii. Care is successfully transitioned to a participating provider.
- iii. Benefit limitations are exceeded.
- iv. Time period approved for COC coverage is exceeded.

B. Identify Customers to be Notified:

1. Behavioral Health will make a best effort to identify and notify all customers in active treatment. Customers in active treatment are defined by:
  - a. Customers receiving care by a practitioner within 12 months preceding the date on which practitioner terminates from the network.
2. Behavioral Health's electronically generated reports will capture this population by identifying customers with claims in the 12 months period prior to decision date.

C. Implement Notification Process:

1. Any of the following areas -- Professional Relations, Credentialing Committees, Operating Unit staff, Senior Managers, etc. -- may submit a Practitioner Termination Form to Network Operations. Network Operations processes terminations requests within 2 business days of receipt of a request.

2. Network Operations

- a. Will verify that termination is contractually permissible and establishes the termination effective date 60 days from the date of written notification from practitioner (for those practitioners voluntarily leaving the network).
- b. Will enter practitioner terminations in the database so that reports run by the field staff will reflect termination decisions. The entry shows up in the Data Warehouse report called "Contract Status Change Report."

3. National Operations Administration Team

- a. Will run weekly reports of all practitioners terminated and customers affected by the termination.
- b. Will ensure that the report does not contain duplicate names.
- c. Will document case notes that a termination notification letter is being sent to customer. Behavioral Health will use a letter format that fulfills customer and regulatory requirements.
- d. Will prepare and mail letters to customers.
- e. Will ensure that all letters have the correct telephone number for the appropriate Operating Unit or National Care Center, should the customer feel a need for more case coordination or transition.
- f. Will file copies of weekly customer reports and letter templates on disk or shared drive for auditing purposes.
- g. Will post to a shared drive, or deliver upon request, appropriate materials for sites to conduct clinical follow-up.

D. In accordance with ethical standards, community practice guidelines, the practitioner's contract, and the Provider Guide, practitioners who choose to leave the network are expected to provide timely notification to customers, facilitate a smooth transition, and

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coordinate the process with Behavioral Health. Furthermore, practitioners should identify high-risk customers and promptly inform Behavioral Health of any additional support required for these individuals.

- E. If a practitioner's contract is discontinued, Behavioral Health permits continuation of care with the terminated practitioner for the duration of the current period of active treatment, or up to 90 calendar days for clients receiving ongoing treatment for chronic or acute behavioral health conditions, whichever is shorter. Furthermore, Behavioral Health requires, by contract, that practitioners continue to provide services at the agreed-upon rate until treatment concludes or the client has been securely transitioned to another provider.
- F. Client termination notifications are the responsibility of the employer or plan sponsor.
- G. Process for COC (customer process)
  - 1. Requests for COC should be submitted no later than 90 calendar days after the customer is notified of the provider termination. Consideration may be given to requests received after the specified time period if the request was delayed due to circumstances beyond the customer's control (e.g. late notification of health care professional termination).
  - 2. The following COC requests may be approved for reimbursement of the terminating provider at an in-network benefit level for up to 90 calendar days, or according to federal/state law, and is provided ending on the earlier of
    - a. the 90-day period beginning on such date; or
    - b. the date on which such individual is no longer a continuing care patient with respect to such provider or facility
  - 3. Clinical Staff:
    - a. Will review cases needing clinical follow-up.
    - b. Will document efforts to coordinate with practitioner and report the conduct of any practitioner refusing to cooperate to professional relations for appropriate documentation.
    - c. For practitioners terminated immediately for cause, Network Operations will send practitioners a letter with instructions for transitioning customers. In addition, Network Operations will alert Clinical Staff who will determine if customers require telephonic contact in addition to the letters of notification. Clinical staff, based on level of treatment and clinical needs of customer, will telephone customers that are high risk or require contact to ensure appropriate transition of care.
    - d. Will document in case notes that clinical follow-up (when applicable) to assist customers in developing a plan to transition care has occurred.
  - 4. Peer review
    - a. For non-routine services that require authorization, requests which cannot be approved by the behavioral care manager are referred to a Medical Director for determination. The Medical Director reviews the treating provider's treatment plan to assess the individual health care needs of the customer and ensure a reasonable transition period to continue their course of treatment. Exceptions may be made on a case-by-case basis to authorize periods longer than the

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standard 90 calendar days to preserve continuity of care for a defined and limited treatment interval.

- b. The Medical Director will complete the required documentation and will forward to the appropriate staff member for recording in UM system and customer and/or provider notification.
- c. Coverage determination letter is sent to the customer and/or requesting provider. An adverse determination will include the rationale for the decision and guidance on obtaining information on participating providers.

H. State Law Exceptions:

1. Some states may require a shorter notification timeline than Accreditation or CMS standards. Operating Units should be aware of state variances and adjust local policies to comply with state time frames as needed.

## Compliance Measures

Case record review shall indicate:

1. Compliant notification to customer of change in practitioner network status and instructions on how to contact Behavioral Health for assistance in the transition of care.
2. Where indicated, case notes will show clinical follow-up and efforts to transition care.
3. Where customers at high risk are pro-actively identified, case record will indicate telephonic outreach with assistance to assure continuity and coordination in the transition of care.

The Behavioral Health Quality Committee will monitor compliance with this policy by reviewing termination letters and updates.

## Attachment A – State Specific Turnaround Times

### ARIZONA

ARS 20-1057.04

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**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**

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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.

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## **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:

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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.

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