Policy:	GG.1304
Title:	**Continuity of Care During Health Network or Provider Termination**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 01/29/2025*
Effective Date:	02/04/2003
Revised Date:	01/01/2025
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes coverage and continuity of care guidelines for a Member who is involuntarily required to change a Health Network or Provider.

II. POLICY

A. CalOptima Health or a Health Network shall ensure Continuity of Care for a Member.

B. CalOptima Health or a Health Network may require a Member to change his or her Health Network or Provider involuntarily due to special circumstances including, but not limited to, suspensions or non-renewal of a Health Network or Provider's contract with CalOptima Health or a Health Network, including termination, suspensions, and exclusion from the Medi-Cal program as effectuated by the Department of Health Care Services (DHCS).

1. CalOptima Health or a Health Network shall ensure the safe transition to a new Provider for services as necessary and in accordance with this Policy.

C. Health Networks shall notify CalOptima Health of Provider terminations, in accordance with CalOptima Health Policies DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services, EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

D. CalOptima Health shall notify the Member of the new Health Network assignment and the option to select a new Health Network in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process.

E. A Receiving Health Network shall assume full responsibility for a Member's care upon the Affected Member's effective date with the Receiving Health Network when the Member is involuntarily required to change Health Networks.

F. In the event of a change of Health Network under Section II.B. of this Policy, a Receiving Health Network shall ensure the provision of Covered Services to an Affected Member without disruption or delay, including, but not limited to:

1. A Member who is in an active treatment plan;

2. A Member who has medical supply or other needs that affect the Member's quality of life or activities of daily living;

3. A Member who is in the process of evaluation for certain services; and

4. A Member who has other medical care needs.

G. In the event that a Member is required to change Health Networks, CalOptima Health and the Receiving Health Network shall collaborate to coordinate the provision of current and future Covered Services for the Affected Member.

H. Continuity of Care for Medicare Providers of dually eligible members is coordinated per CalOptima Health Policy MA.6021 Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners

I. To ensure that inappropriate disruptions or delays in Covered Services do not occur during an Affected Member's transition to a Receiving Health Network, CalOptima Health and the Receiving Health Network shall make Continuity of Care decisions, in accordance with the guidelines set forth in this Policy and based on the potential best medical outcome for the Affected Member.

III. PROCEDURE

A. Identification of an Affected Member and the Affected Member's Needs

1. CalOptima Health shall work in collaboration with the terminating Health Network to ensure identification of an Affected Member who is involuntarily required to change Health Networks and identify those Members who are in need of care coordination of Covered Services within a Health Network.

2. CalOptima Health shall provide a Receiving Health Network with information about an Affected Member's Continuity of Care needs as the information becomes available.

3. A Receiving Health Network shall evaluate an Affected Member's need for Covered Services and shall authorize appropriate Covered Services for the Affected Member in a timely manner in order to not delay or interrupt the Affected Member's active treatment plan, in accordance with the provisions of this Policy.

B. Notice to Affected Members of Health Network Termination

1. CalOptima Health shall send written notice of Health Network termination to the Affected Members no later than thirty (30) calendar days prior to the termination date of a Health Network Contract for Health Care Services.

2. CalOptima Health shall obtain approval from the DHCS of the written notice prior to sending the notice of Health Network termination to Affected Members.

C. CalOptima Health and a Health Network shall use the following Continuity of Care guidelines to provide continued Covered Services to an Affected Member so as to not cause an interruption or delay for the Affected Member:

1. A Receiving Health Network shall provide an Affected Member, who satisfies the Continuity of Care requirements set forth in CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services, with Continuity of Care with an existing out-of-network provider for the remaining duration of the original Continuity of Care period.

2. A Receiving Health Network shall honor an authorization for a Scheduled Elective Surgery for an Affected Member authorized by the terminating Health Network, unless the Receiving Health Network is able to arrange comparable services without delay or interruption to the Affected Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

3. A Receiving Health Network shall allow an Affected Member who is in the course of oncology treatment to continue his or her course of treatment with the Affected Member's existing Provider as set forth below:

    a. The Receiving Health Network shall evaluate an Affected Member's oncology treatment plan and determine whether it is appropriate to transfer the Affected Member's oncology care services safely to another Provider without delay or interruption to the active treatment plan.

    b. If the Receiving Health Network determines that transferring the Affected Member's oncology care to another Provider may potentially result in an adverse medical outcome or detrimentally affect the Affected Member, the Receiving Health Network shall authorize the Affected Member's oncology services under the Affected Member's existing Provider until the active treatment plan is completed.

4. A Receiving Health Network shall allow an Affected Member, who is in the process of a transplant evaluation to complete transplant care services with the Affected Member's existing Provider. Transplant coordination of care for an Affected Member shall be managed in accordance with CalOptima Health Policy GG.1313: Coordination of Care for Transplant Members.

5. A Receiving Health Network shall allow an Affected Member, who is receiving acute inpatient services on the effective date of the Receiving Health Network change and is expected to have a remaining length of stay less than or equal to three (3) calendar days, to continue his or her acute care stay in the current inpatient setting.

6. A Receiving Health Network shall authorize an Affected Member, who has a remaining length of stay in an acute inpatient setting of more than three (3) calendar days, to stay in the existing acute inpatient setting until the Receiving Health Network can arrange for the safe transfer of the Affected Member to another acute care facility that can provide comparable services.

7. If it is necessary for an Affected Member to reschedule post-surgical physician visits after the effective date of the Receiving Health Network change, the Receiving Health Network shall authorize the Affected Member's remaining post-surgical visits that were included under a previous global authorization with the surgeon who performed the surgery pursuant to community standards and Medical Necessity.

8. A Receiving Health Network shall authorize continued obstetrical services for an Affected Member, including delivery and the immediate postpartum period, with the Affected Member's existing Provider and hospital if the Affected Member is in her second (2nd) or third (3rd) trimester of pregnancy.

9. If an Affected Member is receiving dialysis services, a Receiving Health Network shall authorize continued dialysis services with the Affected Member's existing dialysis center and nephrologist until the Receiving Health Network has evaluated the Affected Member's dialysis treatment plan and arranged for the Affected Member's safe transfer to another dialysis center or nephrologist without a delay or interruption in service.

10. If an Affected Member has a scheduled diagnostic and Ancillary Service on a date after the Affected Member's effective date of the Health Network change, the Receiving Health Network shall authorize the diagnostic or Ancillary Service with the previously scheduled Provider unless the Receiving Health Network is able to arrange comparable services with another Provider without a delay or interruption in service.

11. If an Affected Member receives injectables as part of an active treatment plan, a Receiving Health Network shall ensure that the prescribed injectables are continued without delay or interruption in accordance with the Affected Member's active treatment plan until the Receiving Health Network has re-evaluated the Affected Member's active treatment plan.

12. If an Affected Member receives long term acute care services, a Receiving Health Network shall authorize the long term care acute care services at the Affected Member's existing facility until the Receiving Health Network has re-evaluated the Affected Member and provides for the safe transfer of the Affected Member's care to an alternate facility, with consideration of family or guardian wishes.

13. A Health Network that authorizes the purchase of Durable Medical Equipment (DME) for an Affected Member shall pay for the cost of the DME even if the delivery of the DME occurs after the Affected Member's effective date of the Health Network change.

14. A Receiving Health Network shall continue to provide an Affected Member with the same medical supplies, quantities, or equipment without disruption or delay in services until the Receiving Health Network has evaluated the Affected Member's medical supply needs.

15. If, after consultation with the Receiving Health Network, the CalOptima Health Chief Medical Officer (CMO), or his or her Designee, determines certain services are required and the Receiving Health Network refuses to provide them, the CMO may authorize these services on behalf of the Receiving Health Network.

16. If a Receiving Health Network modifies, delays, denies, or takes any other action that triggers Aid Paid Pending an appeal, the Receiving Health Network shall follow Member notification requirements and related provisions, in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

17. If CalOptima Health or a Health Network requires a Member to change his or her Provider involuntarily due to suspensions, decertification, or non-renewal of a Health Network or Provider's contract with CalOptima Health or a Health Network, including termination, suspensions, and decertification from the Medi-Cal program as effectuated by DHCS, CalOptima Health or a Health Network shall coordinate with the receiving Provider for ongoing services and treatment.

a. CalOptima Health or a Health Network shall ensure the terminated, suspended, or decertified Provider does not receive payment for Medi-Cal services provided on or after the effective date of action in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services.

b. CalOptima Health or a Health Network shall communicate the notification to the Affected Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services.

18. A Receiving Health Network shall pay for the Covered Services furnished to an Affected Member by the Affected Member's existing Provider as authorized by the terminating Health Network to maintain Continuity of Care in accordance with this Policy. The Receiving Health Network shall pay a Non-Contracted Provider for such items and services at the Medi-Cal Fee Schedule rate or, if inpatient services, at the CalOptima Health rate.

D. For a California Children's Services (CCS)-eligible transitioning to CalOptima Health's WCM program who is required to change to a new Health Network, the following Continuity of Care requirements shall also apply:

1. WCM Continuity of Care is available to the CCS-eligible Member in accordance with CalOptima Health Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Health Services, as follows:

a. Specialized or Customized Durable Medical Equipment (DME);

b. Authorized prescription drugs that is part of the therapy for the CCS-eligible Condition of the CCS-eligible Member.

2. The CCS-eligible Member is provided with written notice explaining the Member's right to request an extension of the Continuity of Care period and the WCM appeal process for Continuity of Care limitations, in accordance with CalOptima Health Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Health Services.

3. The CCS-eligible Member is allowed to receive services for the Member's CCS-eligible Condition from a CCS Provider outside of the Receiving Health Network for Continuity of Care purposes, in accordance with the requirements of this Policy, or if there are no CCS Providers that meet the Member's CCS medical needs within the Receiving Health Network's network.

4. The CCS-eligible Member is permitted through Continuity of Care to continue to receive services from a Provider in the Member's previous Health Network, including their assigned Primary Care Provider, for up to twelve (12) months, in accordance with CalOptima Health Policy GG.1325: Continuity of Care Members Transitioning into CalOptima Health Services.

5. The Receiving Health Network shall allow, upon request, the CCS-eligible Member to maintain access to CCS Providers with whom the Member has an existing relationship for up to twelve (12) months, in accordance with Welfare and Institutions Code section 14094.13, under the following conditions:

a. The CCS-eligible Member has seen the out-of-network CCS Provider for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima

Health or the initial assigned Health Network assumed responsibility for the Member's CCS care under the WCM program.

b. The out-of-network CCS Provider accepts the Receiving Health Network's rate for services offered or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the out-of-network CCS Provider enters into an agreement on an alternative payment methodology mutually agreed to by the out-of-network CCS Provider and the Receiving Health Network.

c. The Receiving Health Network confirms that the out-of-network CCS Provider meets applicable professional standards, including CCS standards, and has no disqualifying quality of care issues.

d. The out-of-network CCS Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS.

e. The out-of-network CCS Provider provides treatment information to the Receiving Health Network, to the extent authorized by the State and federal patient privacy provisions.

6. The CCS-eligible Member may petition the Receiving Health Network for an extension of the Continuity of Care period. If the Receiving Health Network does not approve the extension, the CCS-eligible Member may appeal this decision in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services and GG.1510: Member Appeal Process.

E. In the event that the guidelines set forth in this Policy do not address an Affected Member's particular continuity of care circumstance or need during the Affected Member's transition from a Health Network, CalOptima Health's CMO or his or her Designee shall render final determination of a Health Network's decision regarding the authorization of Covered Services.

F. To ensure the Continuity of Care for an Affected Member, a Receiving Health Network shall coordinate the Affected Member's Covered Services and the payment of Covered Services to a Provider when the prior Health Network authorized the Affected Member's care with the existing Provider and there is an existing course of treatment. The Receiving Health Network shall reimburse a Non-Contracted Provider in accordance with the provisions of this Policy.

G. A Receiving Health Network shall notify an Affected Member of its decision to approve, modify, delay, or deny a request for authorization of Continuity of Care, in accordance with the guidelines set forth in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

H. CalOptima Health or a Health Network shall provide continued Covered Services to an Affected Member so as to not cause an interruption or delay using the following continuity of care guidelines:

1. CalOptima Health or a Health Network shall ensure continuation of treatment through the current period of active treatment, not to exceed twelve (12) months except as provided in Section III.D. of this Policy for Members eligible with the WCM program.

2. CalOptima Health or a Health Network shall ensure continuation of care through the postpartum period for a Member in their second (2nd) or third (3rd) trimester of pregnancy.

I. CalOptima Health or a Health Network shall notify an Affected Member of Provider termination, in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services.

J. CalOptima Health may impose Sanctions on a Health Network, including and without limitation, financial penalties or termination, in accordance with CalOptima Health Policy HH.2002: Sanctions, when the Health Network fails to comply with the requirements of this Policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers of Covered Services
D. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
E. CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory
F. CalOptima Health Policy GG.1313: Coordination of Care for Transplant Members
G. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
H. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
I. CalOptima Health Policy GG.1510: Member Appeal Process
J. CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
K. CalOptima Health Policy HH.2002: Sanctions
L. CalOptima Health Policy MA.6021 Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners
M. Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontract Terminations (supersedes APL 16-001)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/10/2009	Department of Health Care Services (DHCS)	Approved as Submitted
09/11/2013	Department of Health Care Services (DHCS)	Approved as Submitted
10/14/2015	Department of Health Care Services (DHCS)	Approved as Submitted
01/31/2018	Department of Health Care Services (DHCS)	Approved as Submitted
04/22/2020	Department of Health Care Services (DHCS)	Approved as Submitted
07/23/2021	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
02/04/2003	Regular Meeting of the CalOptima Board of Directors
02/06/2020	Regular Meeting of the CalOptima Board of Directors
06/03/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/04/2003	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2007	GG.1316	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2010	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	01/01/2012	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2013	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Reviewed	07/01/2014	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	07/01/2015	GG.1304	Continuity of Care During Health Network Termination	Medi-Cal
Revised	04/01/2016	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	11/01/2017	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	10/01/2018	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	02/06/2020	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	06/03/2021	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	09/01/2022	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	04/01/2023	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal
Revised	01/01/2025	GG.1304	Continuity of Care During Health Network or Provider Termination	Medi-Cal

IX. GLOSSARY

Term	Definition
Affected Member	A Member who is involuntarily transitioning between Health Networks or Providers due to circumstances that include, but are not limited to the termination or non-renewal of a Health Network Contract.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a notice of action of intent to terminate, suspend, or reduce an existing authorized service.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
California Children's Services-Eligible Condition	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Provider	Any of the following Providers when used to treat Members for a CCS condition: 1. A medical Provider that is paneled by the CCS program, pursuant to Health and Safety Code (H&S), Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106. 2. A licensed acute care hospital approved by the CCS program. 3. A special care center approved by the CCS program.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Continuity of Care	Services provided to a Member rendered by an out-of-network Provider with whom the Member has a pre-existing Provider relationship.
Covered Service	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services),

Term	Definition
	Subsection F4 regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

Term	Definition
	16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME)	Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Receiving Health Network	A Health Network to which a Member is transitioning.
Scheduled Elective Surgery	Non-urgent or non-emergent procedures to treat disease, injury, or deformity by physical operation or manipulation, which are requested by the treating physician and authorized by the Health Network to occur within sixty (60) days after transitioning to the Receiving Health Network.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible Conditions.