OLIVE VIEW-UCLA MEDICAL CENTER
POLICY & PROCEDURE

NUMBER: 3101
VERSION: 2

SUBJECT/TITLE: CARE TRANSITION

POLICY: Olive View-UCLA Medical Center (OVMC) shall provide continuing coverage of services by a non-participating provider for newly enrolled SPD/members who transition from Fee-For-Service (FFS) Medi-Cal to Medi-Cal Managed Care and request Continuity of Care. Continued access will be provided for up to 12 months to an out-of-network provider when:

- It has been determined that the member had an ongoing relationship with the provider as verified through FFS utilization data provided by Department of Health Care Services (DHCS)
- There are not quality of care issues with the provider
- The provider will accept Medi-Call FFS reimbursement rates

PURPOSE: To describe the process for continuing medical services for members/patients who met the criteria to continue services with a terminated provider or non-participating provider.

DEPARTMENTS: AMBULATORY CARE

DEFINITIONS: **Non-participating Provider (NPP)**: For the purpose of this policy, refers to a provider who is not a DHS provider.
Existing Relationship: The member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in Medi-Cal Managed Care for a non-emergency visit.
Continuity of Care: The lack of interruption in needed care, and the maintenance of the relatedness between successive sequences of medical care. A fundamental feature of continuity is the preservation of information about past findings, evaluations and decisions, and the use of these in current management.
Transition In Care: A set of actions designed to ensure the coordination and continuity of care as members transfer between locations or different levels of care in the same location. It includes practitioners and/or settings or other changes in which different practitioners become active or inactive in providing ongoing care for a member.

PROCEDURE:

1. When the benefit coverage for services is limited or ends while a member still needs care, OVMC shall offer to educate the member about alternatives for continuing care and how to obtain care as appropriate.
   A. OVMC shall have a transition of care plan to assist members effected by the termination of a provider but still in need of care.

2. Members, who are receiving approved services but whose benefit coverage ends when they still need the medically necessary care, may be identified through:
   A. Requests for an extension of previously approved services that could not be granted due to benefits limitations but which the member still needs.
   B. Daily service coordinator reports. PCMH service coordinator's shall:
      - Be responsible for identifying available resources within the community.
      - Discuss alternative care and resources available to the member.
      - Seek assistance from DHS/MCS case manager in coordinating with Health Plan Member Services, should the member require disenrollment.
      - The MCS case manager will facilitate any coordination activity and assist OVMC's service coordinator, as needed/requested.

REFERENCES/ AUTHORITY: MCS-UM Policy#.0022 Continuity and Coordination of Care
Health & Safety Code, Sections 1363, 1373, 1373.65, 1373.95
Title 28 CCR Section, 1300.61.1.3(3) & 1300.71; AB 1288
Department of Health Care Services All Plan Letter 15-019 and 15-001

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