Policy:	AA.1000
Title:	**Medi-Cal Glossary of Terms**
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Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Michael Hunn 10/07/2025*
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I. PURPOSE

This policy defines terms used in CalOptima Health's Medi-Cal policies and procedures, unless otherwise expressly stated.

II. DEFINITIONS

340B Drug Pricing Program: Program established pursuant to section 340B of the Public Health Service Act, which limits the cost of outpatient drugs to covered entities as defined by 340B(a)(4) of the Public Health Service Act.

Abuse: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

Access Controls: Controls that identify and authenticate a user to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a user is entitled to have.

Accusation: A legal document that begins the formal disciplinary process after an investigation finds evidence that the Physician has violated the laws governing the Physician's practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated and is served on the Physician.

Active Status: A PCP's and Practitioner's contract effective date with CalOptima Health or a Health Network. Active status for a PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and /or Practitioner is approved to provide services to Members within that group.

Activities of Daily Living (ADL): Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.

Acute Administrative Days: An authorized inpatient day for a Member who no longer meets medical criteria for inpatient services at an acute care hospital and is unsafe for discharge based on pending placement or Social Needs.

Acute Condition: A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

Add-On Payment: A Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from CalOptima Health.

Administrative Costs: Only those costs that arise out of CalOptima Health's operations as specified in 28 California Code of Regulations (CCR) section 1300.78.

Administrative Day: An authorized inpatient day for a Member who no longer meets medical criteria for inpatient services at an acute care hospital and is unsafe for discharge based on pending placement or Social Needs.

Administrative Hold: A cease in reimbursement by CalOptima Health for Covered Services related to a Transplant evaluation to a Health Network pending resolution of administrative issues. CalOptima Health's Transplant Committee reviews all Administrative Hold cases on an individual basis.

Administrative Subcontractor: A Subcontractor that contractually assumes administrative obligations of CalOptima Health under the Contract. Administrative obligations include functions such as credentialing verification or claims processing; however, functions related to coordinating or directly delivering health care services to Members, such as Care Coordination are not administrative functions.

Admission, Discharge, and Transfer (ADT) Feed: A standardized, real-time data feed sourced from a health facility, such as a hospital, that includes Members' demographic and healthcare encounter data at time of admission, discharge, and/or transfer from the facility. Demographic information within the feed must meet requirements of the most recent version of the California Data Exchange Framework's Technical Requirements for Exchange Policy and Procedure and conform to United States Core Data for Interoperability (USCDI) requirements of the California Data Exchange Framework.

Adult Day Health Care (ADHC): An organized day program of therapeutic, social and health activities and services provided to persons fifty-five (55) years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in 22 CCR section 78007.

Advance Directives: A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.

Adverse Activity: A sanction, exclusion, suspension, revocation of licensure, or felony as a result of quality of care issues and Complaints.

Adverse Benefit Determination: Any of the following actions taken by CalOptima Health:

1. The denial or limited authorization of a requested service, including determinations based on the type or Level of Service, Medical Necessity;
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a 'clean claim' at 42 CFR section 447.45(b) is not an Adverse Benefit Determination.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals.

6. The denial of the Member's request to obtain services out – of – network when a Member is in an area with only one Medi-Cal managed care health plan; or;
7. The denial of a Member's request to dispute financial liability.

Adverse Childhood Experiences (ACEs) Screening Services: Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages zero (0) to nineteen (19) years) or a qualifying ACEs questionnaire for adults (ages eighteen (18) years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are eighteen (18) or nineteen (19) years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages twenty (20) years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the ten (10) original categories of the ACEs to qualify.

Affected Member: A Member who is involuntarily transitioning between Health Networks due to circumstances that include but are not limited to the termination or non-renewal of a Health Network Contract.

Affiliate: An entity or an individual that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control of CalOptima Health and that provides services to or receives services from CalOptima Health.

Affiliated Orange County System Hospital: A hospital located in Orange County, California, that is owned directly through the same wholly owned entity, as the Primary Hospital.

Aid Code: The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

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 Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.

Alcohol Misuse Screening and Counseling (AMSC): Comprehensive and integrated approach to the early delivery of intervention and treatment services through universal screening for Members experiencing alcohol and substance use disorders and for Members at risk.

Allied Health Personnel: Specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.

All Plan Letter (APL) / Policy Letter (PL): A binding document that has been dated, numbered, and issued by DHCS that provides clarification of CalOptima Health's contractual obligations, implementation instructions for CalOptima Health's contractual obligations due to changes in State and federal law, or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Alternative Access Standard (AAS): An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

Alternative Birthing Centers (ABCs): Also referred to as Free Standing Birth Centers, ABCs are specialty clinics that provide an alternative to traditional, hospital-based maternity care. These clinics are authorized to bill Medi-Cal for Comprehensive Perinatal Services Program (CPSP), obstetrical, and delivery services.

Alternative Format Selections (AFS): The choice a Member or a Member's Authorized Representative (AR) makes to receive information and materials in an alternate format, such as braille, large font, and electronic media, including audio or data compact discs.

Ambulatory Surgery Center (ASC): A clinic that is not part of a hospital and that provides ambulatory surgical care for patients who remain less than twenty-four (24) hours.

American Indian: A Member who meets the criteria for an "Indian" under 42 Code of Federal Regulations (CFR) section 438.14(a).

American Indian Health Service Facilities: Facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, in order to provide services to the eligible Indians within a specified geographic area pursuant to 22 CCR section 55000 et seq. Indian Health Services Facilities includes "Indian health care providers" as defined in 42 CFR section 438.14(a).

American Indian Health Services Program: Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

Ancillary Services: All Covered Services that are not physician services, hospital services, or long-term care services.

Annual Financial Reporting Form (AFRF): CalOptima Health's financial reporting template which is to be completed and submitted by a Physician Hospital Consortium (PHC) and a Shared Risk Group (SRG) annually, one hundred twenty (120) calendar days after calendar year end, and as otherwise determined necessary by CalOptima Health.

Annual Risk Assessment: A screening tool to stratify level of risk (high, medium, low) based upon vulnerability to potential non-compliance within applicable policies and procedures, regulatory standards, and contractual obligations. The risk assessment tool includes a questionnaire with ratings and comments about actions that can be taken to reduce risks, maintain compliance, and prevent deficiencies. A risk assessment should be performed at least annually.

Appeal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions:

1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;
2. A reduction, suspension, or termination of a previously authorized service;
3. A denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim;
4. Failure to provide services in a timely manner; or
5. Failure to act within the timeframes provided in 42 CFR 438.408(b).

Appeal Process: The process by which CalOptima Health and its Health Networks address and provide resolution to all Appeals.

Applicant Pharmacy: A Pharmacy that applies to become part of the Participating Pharmacy Network by submitting a request to the Pharmacy Benefit Manager (PBM).

Application-Programming Interface (API): A way for two or more computer programs to communicate with each other. The calls that make up the API are also known as subroutines, methods, requests, or endpoints.

Assessment: A process or set of questions for defining the nature of a risk factor or problem, determining the overall needs or health goals and priorities, and developing specific treatment recommendations for addressing the risk factor or problem. Health assessments can vary in length and scope.

Assignment (Pharmacy): Any of the following:

1. Change of more than twenty-five percent (25%) of the ownership or equity interest in a Pharmacy (whether in a single transaction or in a series of transactions);
2. The merger, reorganization, or consolidation of a Pharmacy with another entity with respect to which the Pharmacy is not the surviving entity; or
3. A change in the management of a Pharmacy from management by persons appointed or otherwise selected by the governing body of the Pharmacy (e.g., the Board of Directors) to a third-party manager or management company.

Asthma Preventative Services (APS): A service that provides information about the basic facts of asthma, proper use of long – term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms. Asthma preventive services include evidence-based asthma self-management education and in-home environmental trigger assessments, consistent with the National Institute of Health's Guidelines for the Diagnosis and Management of Asthma.

Asynchronous Store and Forward: The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.

Audit: A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.

Audit (Pharmacy): Any review or audit of a Pharmacy performed by CalOptima Health, CalOptima Health's authorized representative, or by any regulatory or law enforcement agency, except, however, any review or audit of a Pharmacy conducted by the PBM or its designee.

Auditing: A formal, systematic, and disciplined approach designed to evaluate and improve the effectiveness of processes and related controls. Auditing is governed by professional standards, completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.

Augmentation and Alternative Communication Device (AAC): A set of tools and strategies that a Member uses to solve every day communicative challenges, including but not limited to, speech, a shared glance, text, gestures, facial expressions, touch, sign language, symbols, pictures and speech generating devices.

Authorization: Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent Authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code section 14100.2.

Authorized Representative (AR): Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.

Authorization Request Form (ARF): CalOptima Health's form to request authorization for Covered Services.

Autism Spectrum Disorder (ASD): A developmental disability originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.

Auto-Assignment: The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.

Automatic Orthopedic Positioning Device (AOPD): A non-standard positioning device (car seat and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over forty (40) pounds or over forty (40) inches in length) who requires positioning options such as pads that assist in head and trunk positioning while being transported in a motor vehicle. An AOPD is not a standard, commercially available car seat, booster seat, or harness that is required by California state law for children under four (4) years of age and under forty (40) pounds.

Auxiliary Aid: Defined as "auxiliary aids and services" in 28 CFR section 36.303(b) that assist disabled Members to communicate, receive and understand information.

Base Community Reinvestment: The minimum level of net income that an managed care plan (MCP) with positive net income is required to invest into initiatives that serve the communities in which the MCP operates, starting with net income based on calendar year (CY) 2024 Contract Revenues for Community Reinvestment activities initiated in CY 2026.

Basic Case Management: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP), or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

Basic Population Health Management (BPHM): An approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).

Behavioral Health: Mental health conditions and Substance Use Disorders (SUD).

Behavioral Health Care: Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.

Behavioral Health Services: Specialty Mental Health Services (SMHS), Non-specialty Mental Health Services (NSMHS), and Substance Use Disorder (SUD) treatment.

Behavioral Health Transformation: Department of Health Care Services (DHCS) implementation of ballot initiative Proposition 1 to modernize the behavioral health delivery system to improve accountability, increase transparency, and expand the capacity of behavioral health care facilities.

Behavioral Health Treatment (BHT): Services and treatment programs, including applied behavioral analysis and other evidence-based intervention programs that prevent or minimize the adverse effects of symptoms and behaviors that may interfere with learning and social interaction and promote, to the maximum extent practicable, the functioning of a Member under twenty-one (21) years of age including those diagnosed with

Autism Spectrum Disorder (ASD) with ASD, as determined to be medically necessary for the child by a licensed physician, or psychologist.

Behavioral Health Treatment (BHT) Services: Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.

Behavioral Health Treatment (BHT) Service Providers: Providers that are State Plan-approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals.

Benchmark: Performance information used to identify the operational and clinical practices that lead to the best outcome.

Beneficiary Identification Card (BIC): A plastic card issued by DHCS to a Member confirming Medi-Cal eligibility.

Biomarker Test: A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.

Blood Lead Screening: Testing an asymptomatic child for lead poisoning by analyzing the child's blood for concentration of lead.

Board Members: Members of the CalOptima Health Board of Directors.

Board Certification/Certified: Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.

Boarder Baby: A hemodynamically medically stable newborn receiving basic medical and nursing care who could be discharged but is awaiting placement, or who is being held as an inpatient until such newborn gains sufficient weight to be discharged.

Border Community: A community located outside the State of California that is not considered to be out of state for the purpose of excluding coverage by the MHPs because of its proximity to California and historical usage of providers in the community by Medi-Cal beneficiaries.

Border Hospital: Hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.

Bone Marrow Transplant (BMT): A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient, a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated donor (MUD) with human histocompatibility antigens (HL-A) that meet Department of Health Care Services (DHCS) standards.

Breach: The acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of Title 45, CFR, Section 164.402, which compromises the security or privacy of Protected Health Information (PHI).

Breach excludes:

1. Any unintentional acquisition, access, or use of protected health information by a workforce Member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part.
2. Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part.
3. A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Bright Futures Periodicity Schedule: The Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care and guidelines published by the American Academy of Pediatrics and Bright Futures, in accordance with which all Members less than twenty-one (21) years of age must receive well child assessments, screenings, and services.

Bright Steps Program: CalOptima Health's pregnancy, postpartum and infant program that provides perinatal support services to Medi-Cal members. Services are offered to members for the duration of their pregnancy and up to one (1) year after delivery. Services include nutrition, health education, psychosocial assessments, referrals, and other appropriate interventions.

Business Associate: Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:

1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a Member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or
2. Provides, other than in the capacity of a Member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
3. A covered entity may be a business associate of another covered entity.
4. Business associate includes:
    a. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.
    b. A person that offers a personal health record to one or more individuals on behalf of a covered entity.
    c. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions: Those terms and conditions issued and approved by the federal Centers for Medicare and Medicaid Services (CMS), including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative pursuant to Article 5.1 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions (W&I) Code. CalAIM Terms and Conditions must include, at a minimum, any terms and conditions specified in the following:

1. California Advancing and Innovating Medi-Cal Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1315 of Title 42 of the United States Code, including for any applicable extension period, or for any period otherwise approved therein.
2. Any associated Medicaid Waivers as approved by CMS pursuant to Section 1396n of Title 42 of the United States Code, including but not limited to the CalAIM Section 1915(b) Waiver Control Number CA 17.R10, that are necessary to implement a CalAIM component, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

California Children's Services (CCS) Case Manager: An individual identified as a single point-of-contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services under the California Children's Services (CCS) Program.

California Children's Services (CCS)-Eligible Conditions: 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) Liaison: Primary points of contact for the coordination of services between CalOptima Health and county CCS Program, who ensure the appropriate communication and care coordination are ongoing between the CalOptima Health and county CCS Program, facilitate quarterly meetings, and provide updates to the county CCS Program as appropriate.

California Children's Services (CCS) Program: A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.

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.

California Department of Corrections and Rehabilitation: Manages the State of California's prison system including. rehabilitation, community reintegration and restorative justice.

California Medicaid State Plan: A comprehensive description of California's State Medicaid Program, based upon the requirements of Title XIX of the Social Security Act, that serves as a contractual agreement between the State of California and the federal Centers for Medicare and Medicaid Services.

California Medical Assistance Commission (CMAC) Rate: The confidential and individual per diem rate for a hospital established by the California Medical Assistance Commission (CMAC).

CalOptima Health Behavioral Health Phone Line: Toll-free telephone number that Providers, Members or individuals acting on behalf of Members can call at any time (twenty-four (24) hours/ seven (7) days a week) to obtain referrals for all CalOptima Health Covered Outpatient Mental Health Services. This line has a live operator at all times and telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

1. Have authority to approve Covered Services;
2. Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and/or
3. In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room.

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.

CalOptima Health Community Supports: Community Supports that CalOptima Health has received approval from the Department of Health Care Services (DHCS) to provide.

CalOptima Health Contracted Hospital: A hospital that has entered into a CalOptima Health Hospital Services Contract to provide:

1. Hospital Services to CalOptima Health Direct Members for which CalOptima Health is financially responsible; and
2. Covered Services to Members Enrolled in a Shared Risk Group for which CalOptima Health is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

CalOptima Health Direct (COHD): A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.

CalOptima Health Direct Administrative (COHD-A): The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members who meet certain eligibility criteria as described in CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.

CalOptima Health Direct (COHD) Member: A Member who receives all Covered Services through CalOptima Health Direct.

CalOptima Health Hospital Services Contract: A contract entered into between CalOptima Health and a Hospital to provide Covered Services to CalOptima Health Members on a Fee-For-Services basis.

CalOptima Health Link: Online web portal available to contracted Providers that allows authorized Users to look up Member claim information, submit referrals, view authorization status, and more, in order to accelerate services and enhance the care provided to their patients.

CalOptima Health Medi-Cal Fee Schedule: Fee schedule adopted by CalOptima Health for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima Health is responsible.

CalOptima Health Network Pharmacy: Any Pharmacy that is credentialed by and contracted with the Pharmacy Benefits Manager (PBM) to provide Pharmaceutical Services to Members.

CalOptima Health Program: A managed care program 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.

CalOptima Health Workforce: This includes any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Capitated Providers: Providers that are reimbursed on a capitation basis.

Capitated Services: Those Covered Services that are provided by a Physician Hospital Consortium (PHC), Health Maintenance Organization (HMO), Shared Risk Physician Group, or other Provider pursuant to a capitation agreement, and which are provided in exchange for a fixed monthly fee without regard to the cost or volume of services or supplies provided.

Capitation Payment: The monthly amount paid to a Health Network by CalOptima Health for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.

Capitation Rate: The per capita rate set by CalOptima Health for the delivery of Covered Services to Members based upon Aid Code, age, and gender.

Care Coordination: Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.

Care Coordination (Care Management Level): Case Management provided to Members who are at moderate risk but still have an acute or chronic medical condition that requires assessment and coordination of resources in order to maintain the Members in the least restrictive setting.

Care Management: A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.

Care Management Plan (CMP): A written plan that is developed with input from the member and/or their family member(s), guardian, authorized representative, caregiver, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences, and make recommendations for service needs.

Care Manager: An individual identified as a single point of contact responsible for the provision of care management services for a member.

Category A Experimental Device: A device for which absolute risk of the device type has not been established, that is, initial questions of safety and effectiveness have not been resolved, and the Food and Drug Administration (FDA) is unsure whether the device type can be safe and effective.

Category B Non-experimental/investigational Device: A device for which the incremental risk is the primary risk in question, that is, initial questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained Food and Drug Administration (FDA) premarket approval or clearance for that device type.

Center of Excellence (COE): A designation assigned to a transplant program by the Department of Health Services (DHCS) upon confirmation that the transplant program meets DHCS' criteria.

Centers for Medicare & Medicaid Services (CMS): The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Certified Nurse Midwife (CNM): A registered nurse who has successfully completed a program of study and clinical experience meeting the State guidelines or has been certified by an organization recognized by the State.

Certified Nurse Practitioner: A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.

Certified Registered Nurse Anesthetist: A registered nurse who has completed a course of training in a School of Anesthesia accredited by the American Association of Nurse Anesthetists.

Cervical Intraepithelial Neoplasia: Changes of the cells in the cervix area that may be a precursor to cancer.

Chain Pharmacy: Multiple licensed retail Pharmacies operated under a single business name and logo in a standardized manner, which follow a uniform set of policies and procedures covering all aspects of their operation, and which are organized under a single ownership and management structure (definition excludes franchises).

Child: A Member/Members less than twenty-one (21) years of age unless otherwise specified.

Child Health and Disability Prevention (CHDP) Certified Provider: A Provider who is certified by the Child Health and Disability Prevention (CHDP) program as eligible for payment for CHDP services.

Child Health and Disability Prevention (CHDP) Program: California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Health Members, the CHDP Program is incorporated into CalOptima Health's Pediatric Preventive Services Program.

Child with Serious Emotional Disturbance (SED): Pursuant to Section 1912(c) of the Public Health Service Act and Section 5600.3 of the Welfare and Institutions Code, children with a serious emotional disturbance are (1) from birth up to age 18; and (2) currently have, or at any time during the last year, had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Children and Youth with Special Health Care Needs (CYSHCN): Children and youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children and youth generally. The identification, assessment, treatment, and coordination of care for CYSHCN shall comply with the requirements of 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).

Chronic Health Condition: A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.

Chronic Illness and Disability Payment System (CDPS): A diagnostic classification system that Medicaid programs can use to make health-based capitated payments for Temporary Assistance to Needy Families (TANF) and disabled Medicaid beneficiaries.

Chronic Mental Disorder: One or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association:

1. Pervasive Developmental Disorders;
2. Attention Deficit and Disruptive Behavior Disorders;
3. Feeding and Eating Disorder of Infancy, Childhood, or Adolescence;
4. Elimination Disorders;
5. Schizophrenia and Other Psychiatric Disorders;
6. Mood Disorders;
7. Anxiety Disorders;
8. Somatoform Disorders;
9. Factitious Disorders;
10. Dissociative Disorders;
11. Gender Identity Disorder;
12. Paraphilia;
13. Eating Disorders;
14. Impulse Control Disorders Not Elsewhere Classified;
15. Adjustment Disorders;
16. Personality Disorders; and/or
17. Medication-Induced Movement Disorders.

Chronically Homeless Member: A Member with a condition limiting the activities of daily living and who has been continually homeless for one (1) year or more, or at least four (4) times in the past three (3) years. In addition, a Member who is currently residing in transitional housing, as defined in Health and Safety Code, Section 50675.2, or who has been residing in permanent supportive housing, as defined in Health and Safety Code, Section 50675.14, for less than two (2) years shall also be considered Chronically Homeless if the Member was Chronically Homeless prior to residence.

Claim Form: A standardized form for Providers to submit health care claims.

Class I recall: A situation in which there is a reasonable probability that the use of or exposure to a product will cause serious adverse health consequences or death.

Class II recall: A situation in which use of or exposure to a product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

Clean Claim: A claim that can be processed without obtaining additional information from the Provider or from a third-party, including invoices that meet DHCS established billing and invoicing requirements.

Clinical Practice Guidelines (CPGs): Systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific circumstances.

Closed Loop Referral: A referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a Known Closure.

Closed Pharmacy: A licensed Pharmacy that is not open to the general public, but either provides Pharmaceutical Services to select patient populations that reside in one (1) or more state-licensed facilities, or to patients residing in their homes, excluding Mail Order Pharmacies and Internet Pharmacies.

Code of Conduct: The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, employees, contractors, and agents are required to adhere.

Cold-Call Marketing: CalOptima Health or its agent's unsolicited personal contact with a Member or a Potential Member for the purpose of Marketing.

Community Based Adult Services (CBAS): Skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.

Community Based Adult Services (CBAS) Discharge Plan of Care: A discharge plan of care based on the Member's Community Based Adult Services (CBAS) assessment that is prepared by the CBAS Provider pursuant to 22 CCR section 78345 before the date of the Member's first reassessment and reviewed and updated at the time of each reassessment and prior to discharge.

Community Based Adult Services (CBAS) Emergency Remote Services (ERS): The following services, provided in alternative service locations such as a community setting or the Member's home, and/or as appropriate, via Telehealth or live virtual video conferencing, as clinically appropriate: professional nursing care, personal care services, social services, Behavioral Health Services, speech therapy, therapeutic activities, registered dietician-nutrition counseling, physical therapy, occupational therapy, and meals.

Community Based Adult Services (CBAS) Individual Plan of Care (IPC): A written plan of care developed by a CBAS center's multidisciplinary team, as specified in the California CalAIM Terms and Conditions, or as specified in any subsequent Demonstration amendment or renewal, or successive Demonstration, waiver, or other Medicaid authority governing the provision of Community Based Adult Services (CBAS).

Community Based Adult Services (CBAS) Provider: An Adult Day Health Care (ADHC) center that is licensed by the California Department of Public Health to provide ADHC services, is enrolled as a Medi-Cal Provider, and has been certified as a Community Based Adult Services (CBAS) Provider by the California Department of Aging.

Community Based-Care Management Entities (CB-CME): Providers within the community that have a contractual relationship with a Health Network, or CalOptima Health

Community Health Assessment (CHA): A systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. Public health departments such as State, local, territorial, or Tribal develop CHAs to meet voluntary Public Health Accreditation Board (PHAB) standards and State Future of Public Health funding requirements. A variety of tools and processes may be used to conduct these population-level assessments. The essential feature, as defined by the PHAB, is that the assessment is developed through a participatory, collaborative process with various key sectors of the community.

Community Health Center: Also known as Community Clinic—a health center that meets all of the following criteria:

1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike;
2. Affiliated with a Health Network or CalOptima Health Direct; and
3. Ability to function as a Primary Care Provider (PCP).

Community Health Improvement Plan (CHIP): The output of the Community Health Assessment (CHA) when produced by public health departments (local, territorial, State, or Tribal) for Public Health Accreditation Board

(PHAB) accreditation, State Local Assistance Spending Plan funding allocation, and non-profit hospitals to meet federal and State requirements.

Community Health Worker (CHW): An individual known by a variety of job titles, such as promoters, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in Department of Health Care Services (DHCS) All Plan Letter (APL) 24-004: Community Health Worker Services Benefit.

Community Health Worker (CHW) Services: Preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified in CalOptima Health's contract with the Department of Health Care Services (DHCS) for Medi-Cal.

Community Hospital: An acute care hospital that is not a Tertiary/Children's or High Acuity Hospital.

Community Reinvestment Plan: A document outlining the reinvestment activities in local communities.

Community Supports: Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

Community Supports Provider: Entities that CalOptima Health has determined can provide Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in the DHCS Contract.

Complaint: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.

Complaint Acknowledgment Letter: A written statement acknowledging receipt of a Complaint.

Complaint Process: The process by which CalOptima Health and its Health Networks address and resolve all Complaints.

Complaint Resolution Letter: A written statement explaining the disposition of a Complaint based on a review of the facts, relevant information, and documentation.

Complete Claim: A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information and information necessary to determine payer liability as defined in Title 28, California Code of Regulations section 1300.71 (a)(10) and (a)(11).

Complex Cancer Diagnosis: A diagnosis for which there is no standard FDA-approved treatment or which known highly effective therapy for metastatic cancer has failed and any of the following diagnoses: hematological malignancies, acute leukemia, advanced, relapsed, refractory non-Hodgkin lymphoma and multiple myeloma, including BPDCN and T-cell leukemias and lymphomas, and advanced stage, relapsed solid tumors refractory to standard FDA-approved treatment options, advanced stage rare solid tumors for which there is no known effective standard treatment options.

Complex Care/Case Management (CCM): An approach to care management that meets differing needs of high- and rising-risk members, including both longer-term chronic care coordination and interventions for episodic,

temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.

Complex Care Management (CCM) Care Manager: An individual identified as a single point-of-contact responsible for the provision of Complex Care Management (CCM) services for a Member.

Complex Case Management Eligible Member: Members who are at high-risk; defined as having medically complex conditions that include the following but is not limited to:

1. Spinal Injuries;
2. Transplants;
3. Cancer;
4. Serious Trauma;
5. AIDS;
6. Multiple chronic illnesses; or
7. Chronic illnesses that result in high utilization.

Or a Member with a Medical Condition and a complex social situation that affects the medical management of the Member's care and requires an extensive use of resources.

Complex Care Needs: Means the multifaceted health and social support requirements of Members who face significant barriers to achieving and maintaining health and stability. This includes individuals with multiple chronic conditions, functional impairments, behavioral health challenges, or those requiring extensive care coordination due to social determinants of health.

Compliance Committee: This CalOptima Health committee consists of executive officers, managers of key operating divisions, and legal counsel and oversees the implementation of CalOptima Health's Compliance Program.

Compliance Issue: An allegation by the claimant that the county has failed to abide by a state hearing decision concerning issues clearly resolved in the order where the county did not have to make further determinations regarding the claimant's eligibility or amount of benefits.

Compliance Program: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, contractors, and providers comply with applicable law and ethical standards.

Compliance Related Issues: Issues which were not resolved in the prior state hearing decision or resulted from the prior hearing decision requiring the county to make further determinations regarding the claimant's eligibility or amount of benefits.

Comprehensive Medical Case Management: Services provided by a Primary Care Provider, in collaboration with CalOptima Health or a Health Network to ensure the coordination of Medically Necessary health care services, the provision of preventive services, in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

Comprehensive Outpatient Rehabilitation Facility (CORF): A CORF is a facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician.

Comprehensive Perinatal Service Provider (CPSP): Any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, family or pediatric nurse practitioner, alternative birth center, a group, any of whose Members is one of the above-named physicians, or any preferred provider organization or clinic holding a valid and current Medi-Cal provider number and certified pursuant to the standards of this section.

Comprehensive Perinatal Services Program (CPSP): Services as defined in Welfare and Institutions Code, Section 14134.5, and Title 22, California Code of Regulations, Sections 51179 and 51348. For CalOptima Health Members, CPSP is incorporated into CalOptima Health's Perinatal Support Services.

Concurrent Request (pharmacy): A request for coverage of pharmaceutical services made while a Member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.

Confidential: Entrusted with private or personal information that is confined to a person or group as opposed to the public.

Confidential Communications: The provision of communications of Protected Health Information (PHI) by alternative means or at alternative locations based upon a Member's reasonable request.

Confidential Documents: Documents that shall be handled in a confidential manner. These include, but are not limited to:

1. Committee minutes and agendas;
2. Peer review reports and findings; and/or
3. Any correspondence or memoranda relating to Confidential issues in which the name of a provider or a Member is included.

Confidential Information: Facts, documents, or records in any form that are recognized as "confidential" by any law, regulation, or contract.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): A multiyear initiative of the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care by developing standardized patient questionnaires that can be used to compare results across sponsors and over time and generate tools and resources that sponsors can us to produce understandable and usable comparative information for both consumers and health care providers.

Contested Claim: A claim submitted for payment that is considered an incomplete claim submission and that is contested by the health plan as a result of the claim not containing all reasonably relevant information to determine payer liability.

Contingent Therapy: A utilization management process which restricts a drug to a specific age, gender, or related drug therapy. If it is Medically Necessary for a Member to use the medication and the contingent therapy restriction is not met, the prescriber can request coverage by submitting a prior authorization request.

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.

Continuous Home Care: Hospice Care provided in the Member's residence, which consists predominantly of skilled nursing care, for a minimum of eight (8) hours in a twenty-four (24)-hour period, for the palliation or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the Member's care.

Contract: A written agreement between DHCS and CalOptima Health.

Contracted CalOptima Health Direct (COHD) Provider or Practitioner: A Provider or Practitioner that has entered into a contract with CalOptima Health to provide services to CalOptima Health Direct Members.

Contracted CalOptima Health Hospital: A hospital that has entered into a CalOptima Health Hospital Services Contract to provide Hospital Services to CalOptima Health Direct Members.

Contracted Fee-For-Service (FFS) Hospital: A hospital that has entered into a CalOptima Health Hospital Services Contract to provide Hospital Services to CalOptima Health Members.

Contracted Provider: A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima Health, its contracted Health Networks or Physician Groups.

Contract for Health Care Services: The written instrument between CalOptima Health and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include all applicable DHCS Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and any Memoranda of Understanding entered into by CalOptima Health that are binding on a Physician Hospital Consortium (PHC), a physician group under a shared risk contract, or an HMO.

Contractor's Representative: An individual appointed by CalOptima Health who is responsible for implementing the contract with DHCS for Medi-Cal receiving notices on this Contract, and taking actions and making representations related to the compliance with this Contract.

Contract Owner: The one individual within CalOptima Health with ultimate responsibility for the relationship between CalOptima Health and the Delegated Entity. Contract Owner responsibilities include, but are not limited to, initial contact, procurement, negotiation of contract terms, compliance remediation, on-going entity relations, site closings, hours of operations, etc. The Contract Owner is the individual with responsibility for ensuring that the documentation regarding the relationship between CalOptima Health and the Delegated Entity is complete and accurate.

Contract Revenues: The amount of Medi-Cal managed health care capitation payments, supplemental payments, additional payments, and other revenue paid to CalOptima Health by DHCS under the DHCS Contract for Medi-Cal.

Contract with the Department of Health Care Services (DHCS): The written instrument between CalOptima Health and the Department of Health Care Services (DHCS) pursuant to which CalOptima Health is obligated to arrange and pay for the provision of Covered Services to Members in the Service Area.

Coordination of Benefits: A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.

Core Service Components (for ECM):

1. Outreach and engagement;
2. Comprehensive assessment and care management plan;
3. Enhanced coordination of care;
4. Health promotion;
5. Comprehensive transitional care;
6. Member and family support; and
7. Coordination of and referral to community and social support services.

Core Specialist: Adult and pediatric providers as specified in Department of Health Care Services All Plan Letter 20-003: Network Certification Requirements, including Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, and Pulmonology.

Correctional Facility: State prisons, county jails, and youth correctional facilities.

Corrective Action Plan (CAP): A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.

Corrective Actions: Specific identifiable activities or undertakings of CalOptima Health which address contract deficiencies or noncompliance.

Cosmetic Surgery: Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Cost Avoid or Cost Avoidance: The practice of requiring Providers to bill liable third parties prior to seeking payment from the Medi-Cal program.

County of Orange Health Care Agency (HCA): The Department of Health Services for Orange County responsible for determining the initial and continued eligibility of an individual for participation in the Medi-Cal program, or providing services as specified in the DHCS Contract for Medi-Cal.

Course of Treatment: Medical or surgical management of a Member intended to ameliorate the basic disease problem.

Covered Entity: A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.

Covered Medication: A medication that is listed on the CalOptima Health Approved Drug List or approved for medical necessity under the prior authorization process.

Covered Services: 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, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health 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, CalOptima Health 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, CalOptima Health 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 twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005;
14. Childhood lead poisoning case management provided by county or State 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;
16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS 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 DHCS APL 22-012.

Credentialing: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership.

Credentialing and Peer Review Committee (CPRC): The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC).

Credible Threat of Violence: A knowing and willful statement or course of conduct that would place a reasonable person in fear for his or her safety or the safety of others and that serves no legitimate purpose.

Critical Incident: Critical Incident refers to any actual or alleged event or situation that creates a significant risk of substantial harm to the physical or mental health, safety or well-being of a Member.

Crossover Claim: A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.

Cultural and Linguistic Services: Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to:

1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs;
2. Providing twenty-four (24)-hour access to interpreter services at Key Points of Contact for all Members;
3. Providing translations of informational materials in Threshold Languages, providing oral translation for other languages upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and
4. Referring Members to culturally and linguistically appropriate community services, as needed.

Cultural Competency: The ability to actively apply knowledge of cultural behavior and linguistic issues when interacting with Members from diverse cultural and linguistic backgrounds. Essential elements of Cultural Competency include:

1. An unbiased attitude and organizational policy that values and respects cultural diversity and respect for the multifaceted nature and individuality of Members;
2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about preventive health, illness and diseases, as well as differing communication patterns;
3. Recognition of the diversity among Members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual orientation, social and historical context, generational, and acculturation status);
4. Skills to communicate effectively with diverse Member populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care;
5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability;
6. Programs and policies that address the health needs of diverse Member populations; and
7. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of Members.

Curative Care: Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress.

Deductible/Co-payment: The amount a Member must sustain for each category of coverage before any benefit becomes payable under the primary/other coverage plan.

Deemed Exhaustion: CalOptima Health's failure to adhere to the notice and timing requirements in responding to a Member's Appeal of an Adverse Benefit Determination (ABD), allowing a Member to immediately request a State Hearing.

De-identified Information: Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.

Delegated Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

Delegated Services: Include, but are not limited to, administration and management services, marketing, utilization management, quality assurance, case management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, disenrollment, billing, sales and adjudicating organization determinations and appeals.

Delegation: Process by which CalOptima Health expressly grants, by formal written agreement, to another entity the authority to carry out a function that CalOptima Health would otherwise be required to perform in order to meet its obligations under its contract with DHCS.

Delegation Agreement: Mutually agreed upon document, signed by both parties, which includes, without limit:

1. CalOptima Health responsibilities;
2. Duration of the agreement;
3. Termination of the agreement;
4. Delegated Entity responsibilities and Delegated Services;
5. Types and frequency of reporting to the Delegated Entity;
   Process by which CalOptima Health evaluates the Delegated Entity's performance (Performance Measurements);
6. Use of confidential CalOptima Health information including Member Protected Health Information (PHI) by the Delegated Entity; and
7. Remedies available to CalOptima Health if the Delegated Entity does not fulfill its obligations.

Delegation Oversight Committee (DOC): A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee.

Denied Claim: A claim for which payment could not be made due to some defect, such as the patient was not a Member, the services were not covered services, the claim was not filed in a timely manner, etc.

Department of Health Care Services (DHCS)-approved Transplant Center: Facilities that are approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal transplants, a DHCS-approved Transplant Center is a facility that:

1. Is certified for, and participates in, the Medicare program; and
2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program.

Department of Health Care Services (DHCS): The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy: The federally required written strategy produced by the State, pursuant to 42 CFR section 438.340 that assesses and improves the quality of health care and services furnished by Medi-Cal managed care health plans.

Department of Health Care Services (DHCS) Contract Manager or DHCS Program Contract Manager: The designated DHCS employee who is the primary contact within DHCS for the DHCS contract, and responsible for receiving and sending notices and other documents from/to CalOptima Health relating to the DHCS contract.

Department of Health Care Services (DHCS) Contracting Officer: The DHCS individual authorized to act on behalf of DHCS to make decisions and direct appropriate actions under this Contract.

Department of Managed Health Care (DMHC): The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Designated Providers: Include the following Providers that are eligible to receive a Directed Payment in accordance with applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period:

1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services;
2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services;
3. Non-contracted GEMT Providers for GEMT Services; and
4. Non-contracted Providers for Abortion Services.

Designated Record Set (DRS): Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is:

1. The medical records and billing records about individuals maintained by or for a covered health care provider;
2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.
4. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

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.

Developmental Disability (DD): As defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability but does not include other handicapping conditions that are solely physical in nature.

Developmental Screening Services: Specified developmental screening services, as listed by the CPT Code for the applicable period, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.

Developmental Surveillance: A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.

Dialysis: A medical procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances. This is a procedure often performed on individuals with extremely poor kidney function.

Directed Payment: An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Directed Payment Initiative: A payment arrangement that directs certain expenditures made by CalOptima Health under the DHCS Contract and that is either approved by Centers for Medicare and Medicaid Services (CMS) as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

Director: Means the Director of the Department of Health Care Services (DHCS).

Disability: A physical or mental condition that limits a person's movements, senses, or activities.

Discharge Planning: Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disclosure: Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations including the following: the release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.

Discrimination Grievance: Any complaint or grievance alleging discrimination prohibited by State non-discrimination law, including, without limitation, the Unruh Civil Rights Act and GC section 11135, and federal non-discrimination law, including, without limitation, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 USC section 18116).

Disease Management: A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that:

1. Supports the physician/Member relationship;
2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and
3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.

Disruptive Behavior: Behavior that consists of intimidating, hostile, or harassing behavior, or any other behavior that disrupts CalOptima Health's course of business. This may include, but is not limited to the following:

1. Verbal abuse such as outbursts, yelling, swearing, or cursing directed at a CalOptima Health employee, subcontractor, or agent;
2. Harassing or intimidating telephone calls, letters, or other forms of written or electronic communications directed at a CalOptima Health employee, subcontractor, or agent; and/or
3. Intimidation or harassment of a CalOptima Health employee, subcontractor, or agent.

Distant Site: A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.

Division of Financial Responsibility (DOFR): A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The

responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.

Document Review: CalOptima Health's examination of policies and procedures, and other written materials documenting a Health Network's performance and compliance with respect to statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health program. Document Review may be conducted off-site, at the CalOptima Health offices, or on-site at a Health Network's place of business.

Donor: An individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant.

Doula: A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024: Doula Services.

Downstream Administrative Subcontractor: A Downstream Subcontractor that contractually assumes administrative obligations of a Subcontractor under the Contract. Administrative obligations include functions such as credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services for Members, such as Utilization Management (UM) or Care Coordination, are not administrative functions.

Downstream Entity: Any party that enters into a written arrangement acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Downstream Fully Delegated Subcontractor: A Downstream Subcontractor that contractually assumes all duties and obligations of CalOptima Health under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.

Downstream Partially Delegated Subcontractor: A Downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Downstream Partially Delegated Subcontractors.

Downstream Subcontractor: An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Downstream Subcontractor Agreement: A written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of CalOptima Health's and Subcontractor's duties and obligations under the DHCS Contract for Medi-Cal.

Drug Medi-Cal (DMC): The State system wherein Members receive Covered Services from DMC-certified Substance Use Disorder (SUD) treatment Providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS): A program for the organized delivery of Substance Use Disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased

local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

Drug Medi-Cal Treatment Program (Drug Medi-Cal): Program under which each county enters into contracts with the State Department of Health Care Services (DHCS) for the provision of various drug treatment services to Medi-Cal recipients or DHCS directly arranges for the provision of these services if a county elects not to do so.

Dual Diagnosis: A simultaneous occurrence of a substance related disorder and a mental disorder in the same individual.

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.

Dyadic Care: To serve both parent(s) or caregiver(s) and child together as a dyad and is a form of treatment that targets family well-being as a mechanism to support healthy child development and mental health. It is provided within pediatric primary care settings whenever possible and can help identify Behavioral Health interventions and other Behavioral Health issues, provide referrals to services, and help guide the parent-child or caregiver-child relationship. Dyadic care fosters team-based approaches to meeting family needs, including addressing mental health and social support concerns, and it broadens and improves the delivery of pediatric preventive care.

Dyadic Services: A family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified. Dyadic Services include Dyadic behavioral health (DBH) well-child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than twenty-one (21) years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.

Early Intervention Services: Those services designed to meet the developmental needs of each eligible infant or toddler and the needs of the family related to the infant's or toddler's development. The services include but are not limited to assistive technology; audiology; family training; counseling and home visits; health services; medical services only for diagnostic or evaluation purposes; nursing services; nutrition services; occupational therapy; physical therapy; psychological services; service coordination; social work services; special instruction; speech and language services; transportation and related costs; and vision services. Early intervention services may include such services as respite and other family support services.

Electronic Consultations (E-consults): Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Electronic Mailbox: A file transmitted through the CalOptima Health File Transfer Protocol (FTP) site or any electronic bulletin board.

Electronic Protected Health Information (EPHI): Has the meaning in Title 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.

Eligible Contracted Provider: An individual rendering Provider who is contracted with CalOptima Health to provide Medi-Cal Covered Services to Members, including eligible Members, assigned to CalOptima Health Direct and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with CalOptima Health does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.

Emergency Management Team (EMT): CalOptima Health team composed of lead staff in charge of authorizing the activation of business contingency operations during or immediately following a disaster, emergency situation, or broad health care surge event in accordance with the CalOptima Health Policy GA.7103: Business Continuity Plan.

Emergency Medical Condition: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily function;
3. Serious dysfunction of any bodily organ or part; or
4. Death

Emergency Medical Transportation (EMT): Transportation services for an Emergency Medical Condition and includes emergency air transportation.

Emergency Preparedness and Response Plan: The plan identified and described in the DHCS contract for Medi-Cal.

Emergency Services: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).

Encounter: An instance of direct Provider-to-Member interaction, regardless of the setting, between a Member and a Provider who is diagnosing, evaluating, or treating the Member's condition.

Encounter Data: The information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member under DHCS Contract and subject to the standards of 42 CFR sections 438.242 and 438.818.

Encryption: The use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.

End Stage Renal Disease (ESRD): That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is

classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.

End Stage Renal Disease Medical Evidence Report - Medicare Entitlement and/or Patient Registration (Form CMS-2728-U3): The Centers for Medicare & Medicaid Services (CMS) registration form for any Member for whom a physician has prescribed a regular course of dialysis or who initially receives a kidney transplant instead of a course of dialysis.

Endorsement: The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima Health does not receive a comparable benefit. Endorsement does not include any educational activity, purchased service, or activity that is included in the definition of Marketing Activities.

Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

Enhanced Care Management (ECM) Lead Care Manager (LCM): A Member's designated Enhanced Care Management (ECM) care manager who works for the ECM Provider organization or as staff of CalOptima Health and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.

Enhanced Care Management (ECM) Member: A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Health Direct.

Enhanced Care Management (ECM) Provider: Community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for Enhanced Care Management (ECM).

Enhanced Care Management (ECM) Streamlined Authorization: Policy which means that select ECM Providers as defined in Exhibit A, Attachment III, Subsection 4.4.7 (*Authorizing Members for Enhanced Care Management*) may initiate ECM services and must be reimbursed for those services for a period of up to 30 calendar days – while the ECM Provider refers the Member to the Contractor and awaits the Contractors' ECM authorization decision.

Enrollment: The process by which a Potential Member becomes a Member of CalOptima Health.

Escheat: The power of a state to acquire title to property for which there is no owner.

Evaluation Services Provider (ESP): A Provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the Provider's Facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s need for power wheelchairs and seating systems or customized modifications to wheelchairs and seating systems.

Evidence-Based: A document or recommendation created using unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.

Excluded Entities or Excluded Providers: Entities, Providers, and individuals that are excluded from participation in federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid/Medi-Cal Fraud.

Excluded or Exclusion: Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.

Excluded Service: A service that is covered by the Medi-Cal program but is not a Covered Service and is carved out of this Contract for the provision of Covered Services.

Exempt Grievance: Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgement and response.

External Quality Review (EQR): The analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that CalOptima Health, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR–related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.

Facets®: Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.

Facility: Any premise that is:

1. Owned, leased, used or operated directly or indirectly by or for CalOptima Health for purposes related in the DHCS Medi-Cal Contract, or
2. Maintained by a Provider to provide services on behalf of CalOptima Health.

Facility Site Review (FSR): A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume Specialty Care Provider offices.

Facility Site Review (FSR) – Ancillary Services: Ancillary services refers to diagnostic and therapeutic services such as, but not limited to radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations.

Facility Site Review (FSR) – CBAS: For purposes of this tool, CBAS services include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on a Member's Individual Care Plan.

Family Linked Member: A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.

Family Planning Services: Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to:

1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning;
2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures;
3. Patient visits for the purpose of Family Planning;
4. Family Planning counseling services provided during regular patient visit;
5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices;
6. Tubal ligations;
7. Vasectomies;
8. Contraceptive drugs or devices; and
9. Treatment for the complications resulting from previous Family Planning procedures.

Family Planning does not include services for the treatment of infertility or reversal of sterilization.

Family Therapy: a type of psychotherapy covered under the Medi-Cal Non-Specialty Mental Health Services (NSMHS) benefit and is composed of at least two family members. Family therapy sessions address family dynamics as they relate to mental status and behavior(s) and is focused on improving relationships and behaviors in the family and between family members, such as between a child and parent(s) or caregiver(s).

Federal Financial Participation (FFP): Federal expenditures provided to reimburse allowable State expenditures made under the approved California Medicaid State Plan, waivers, or other similar federal Medicaid authority.

Federal Hemophilia Treatment Center: A provider that is part of a regional network of comprehensive hemophilia diagnostic treatment centers established and contracted through the Special Projects of Regional and National Significance (SPRANS) under 42 U.S.C. Section 701(a)(2).

Federally Qualified Health Center (FQHC): An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).

Federally Qualified Health Center (FQHC) Look-Alike: An organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant but does not receive grant funding.

Federally Qualified Health Maintenance Organization (FQHMO): A prepaid health delivery plan that has fulfilled the requirements of the Health Maintenance Organization Act, along with its amendments and regulations, and has obtained the federal government's qualification status under 42 USC section 300e.

Federally Required Adult Dental Services (FRADS): Services that relate to diagnosis and provision of dental services on an emergency basis, such as the need for extractions and other oral surgery procedures; for pregnant women; for adult residents of skilled nursing or intermediate care facilities; and dental services rendered as necessary for medical treatments.

Fee-For-Service (FFS): The Medi-Cal delivery system in which Providers submit claims to and receive payments from DHCS for Medi-Cal covered services rendered to Medi-Cal recipients.

Fee-For-Service Amounts: Amounts adopted by CalOptima Health for reimbursement to hospitals, physicians and other providers for medical services rendered (other than on a capitated payment basis) to Medi-Cal beneficiaries for which CalOptima Health is responsible.

Field Testing or Field Test: A testing process to ensure health education materials which are developed, adapted, or obtained from outside sources are appropriate for Member target audiences.

File and Use: A submission to DHCS that does not need review and approval prior to use or implementation, but for which DHCS can require edits on or after implementation.

Finalized Engagement List (FEL): The list to include the DHCS TEL and CalOptima Health Member data created by applying risk stratification criteria for CalOptima Health and CB-CMEs to utilize for Member engagement activities.

Financial Bulletin: A sequentially numbered written communication previously used to inform Providers and Health Networks of changes, updates, or clarification of CalOptima Health financial policies.

Financial Performance Guarantee: Cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which must not be less than one full month's Contract Revenues.

Financial Security Instrument: Time certificate of deposit, irrevocable standby letter of credit, or surety bond naming CalOptima Health as the beneficiary.

Financial Solvency Reserves: Funds comprised of security reserves and/or capitation withhold that are required for the duration of a Physician Hospital Consortium's (PHC), Shared Risk Group's (SRG), or Health Maintenance Organization's (HMO) participation in the CalOptima Health program. These funds are used to protect the interests of and ensure the continuation of health care services to the Members assigned to the PHC, SRG, or HMO; they may also be used for administrative costs directly attributable to a conservatorship, receivership, or liquidation.

Financial Statement: Reports prepared by CalOptima Health to present its financial performance and position at a point in time, and include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).

First Tier Downstream and Related Entities (FDR): Means First Tier, Downstream or Related Entity, as separately defined herein.

First Tier Entity (FTE): Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health program.

Fiscal Year (FY): Any twelve (12)-month period for which annual accounts are kept. The State Fiscal Year (SFY) is July 1 through June 30; the federal Fiscal Year is October 1 through September 30.

Focus Group: A demographically diverse group of people assembled to generate ideas and opinions about a certain topic.

Focused Review: An audit that specifically targets areas of potential deficiency.

Formulary: The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Health Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Freestanding Birth Center (FBC): A health facility that is not a hospital where childbirth is planned to occur away from the pregnant woman's residence, and that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are in their scope of work as defined in 42 USC section 1396d(I)(3)(B).

Full Benefit Dual Eligible Excluded from Cal MediConnect: A Member who is eligible for Medicare Parts A, B, and D, and Full-Scope Medi-Cal but is ineligible for Cal MediConnect due to exclusion criteria.

Full Benefit Dual Eligible Who Opts Out of Cal MediConnect: A Member who is twenty-one (21) years of age or older and is eligible for Medi-Cal, and who is also eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

Full Scope Site Review: An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.

Fully Delegated Subcontractor: A Subcontractor that contractually assumes all duties and obligations of CalOptima Health under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

Gender Dysphoria: Marked in congruence between a person's experienced or expressed gender and their assigned gender. To meet the Diagnostic and Statistics Manual of Mental Disorders (DSM 5) diagnostic criteria for Gender Dysphoria, there must be evidence of clinically significant distress associated with this incongruence.

General Inpatient Care: Services in an acute hospital, skilled nursing facility/Level B, or a hospice facility which is organized to provide inpatient care directly, for the purpose of pain control or acute or chronic symptom management.

Genetic Testing: Each cell in the body has a core structure that contains chromosomes. Each chromosome contains DNA. Genes are segments of DNA that determine specific traits, such as eye or hair color. A mutation is a change in the DNA. A gene mutation is a change in or damage to a gene. A mutation can be inherited or acquired during the lifetime as cells age or are exposed to certain chemicals. These changes can result in genetic disorders and genetic testing can identify changes or alterations in the genes that may cause illness or disease.

Geographic Distribution: Geographic distribution may be expressed via the percentage of Members who have a PCP of each type within a certain number of miles, the number of sites accepting new Members for primary care in each service area, the ratio of Member to PCP availability in each area and a determination of acceptable driving time to primary care sites, the rate of Members who report no problems with getting a personal physician, or results from the CAHPS Survey (3.0 version-Medicaid) in addition to analysis of PCP availability by service area.

Governing Board: CalOptima Health's board of directors or a similar body, and/or its executive management, that has the authority to manage and direct CalOptima Health's affairs and activities, including, but not limited to, approving initiatives and establishing CalOptima Health's policies and procedures.

Governing Body: The Board of Directors of CalOptima Health.

Grievance: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A Complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

Grievance and Appeals Process: The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances and Appeals.

Grievance Process: The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances.

Ground Emergency Medical Transport (GEMT) Services: Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.

Group Setting: A class or other group presentation that is designed specifically for Health Education purposes.

Health Care Delivery Organization (HDO): Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.

Health Care Operations: Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.

Health Disparity: Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.

Health Education Materials: Materials designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, includes updates on current health conditions, self-care, and management of health conditions. Topics may include messages about preventive care, health promotion, screenings, disease management, healthy living, and health communications.

Health Educator: A person qualified by education, training, or experience to develop, coordinate, or present instruction to Members.

Health Effectiveness Data and Information Set (HEDIS®): the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

Health Equity: The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.

Health Inequity: a systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.

Health Insurance Portability and Accountability Act (HIPAA): The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of

HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.

Health Literacy: Defined by Healthy People 2010 as, "the degree to which individuals have the capacity to obtain, process and understand basic (health) information and services needed to make appropriate health decisions."

Health Maintenance Organization (HMO): A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.

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.

Health Network Eligible Member: A Member who is eligible to choose a CalOptima Health, Health Network or CalOptima Health Community Network (CHCN).

Health Network Member: A Member who is enrolled in or receives Covered Services from a Health Network.

Health Network Risk Factor: The weighted average of all Member Risk Scores for Members assigned to that Health Network at a defined time, normalized across all Health Networks to ensure that the aggregate total Capitation Payments to all Health Networks is budget neutral to CalOptima Health.

Health Risk Assessment (HRA): An assessment required for Seniors and Persons with Disabilities. Effective January 1, 2023, HRA assessment requirements for Seniors and Persons with Disabilities are simplified, while specific member protections are kept in place.

Healthcare Effectiveness Data and Information Set (HEDIS®): The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

Hearing Acknowledgment Letter: A written statement acknowledging a request for a hearing by the Complaint Review Panel with respect to the decision set forth in a Complaint Resolution Letter.

High Acuity Hospital: An acute care hospital that meets at least one (1) of the following criteria continuously during the term of its contract:

1. Serves as a sponsoring institution for residency education programs. To qualify as a sponsoring institution for residency education programs, a hospital must be identified by the Accreditation Council for Graduate Medical Education (ACGME) as a sponsoring institution and be listed on the ACGME website.
2. Serves as a regional burn center. To qualify as a regional burn center, a hospital must be identified by the American Burn Association (ABA) and the American College of Surgeons as a verified burn center and be listed on the ABA Website.
3. Provides DHCS-certified or CMS-certified organ transplantation programs. To qualify as a certified organ transplantation program, a hospital must be certified by CMS for Kidney Transplantation or certified by the Department of Health Services for any other type of solid organ or bone marrow transplants.
4. Listed as a Tertiary Center by CCS. To qualify as a hospital identified as a Tertiary Center by CCS, they must be listed on the CCS Website.
5. Meets Leapfrog criteria for full implementation of ICU physician staffing. To qualify as a hospital that meets Leapfrog criteria for full implementation of ICU physician staffing, the hospital must be listed as meeting the criteria on the Leapfrog Website.
6. Meets Leapfrog criteria for Evidence Based Hospital Referral qualifying as Good Early Effort, Good Progress, or Full Implementation in four (4) or more categories. To identify hospitals that meet Leapfrog

criteria for Evidence Based Hospital Referral, they must be listed on the Leapfrog website. To meet this criterion, a hospital must qualify under the status of Good Early Effort, Good Progress or Full Implementation (as defined by Leapfrog) in at least four (4) of the categories. There are currently six (6) categories of types of procedures, but other procedures can be used to qualify if more are added in the future.

High Cost Exclusion Item: Specific high-cost items that are excluded from a Contracted Hospital's outpatient reimbursement or inpatient per diem rate.

High-Risk Member: A Member who has failed to take advantage of necessary health care services, does not comply with his or her medical regimen, needs coordination of multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, suffering from substance abuse, or is the victim of abuse, neglect, or violence, including, but not limited to, the following:

1. Infants;
2. Women;
3. Persons less than twenty-one (21) years of age;
4. Persons with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS);
5. Persons with a reportable communicable disease;
6. Persons who are technology dependent;
7. Persons with multiple diagnoses who require services from multiple health or social service providers; or
8. Persons who are medically fragile.

History and Physical (H&P): The medical assessment carried out by a qualified medical provider summarizing prevalent Member information which may include, but is not limited to, past medical history, current medications, and social history, along with a physical exam to note appearance and vitals.

Home and Community-Based Services (HCBS): Home and Community- Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).

Home Health Agency: A public or private agency or organization that offers home care services including skilled nursing services and at least one other therapeutic service in the residence of the client through physicians, nurses, therapists, social workers, and homemakers whom they recruit and supervise.

Home Health Services: Medically related services provided to Members in a home setting rather than in a medical facility such as a hospital or a primary health care center.

Homeless or Homelessness: Members experiencing homelessness include the following:
1. An individual or family who lacks adequate nighttime residence;
2. An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation;
3. An individual or family living in a shelter;
4. An individual exiting an institution into homelessness;
5. An individual or family who will imminently lose housing in the next thirty (30) days;
6. An unaccompanied youth, and homeless families and children and youth defined as homeless under other federal statutes; or
7. Individuals fleeing domestic violence.

Hospice Care: The provision of palliative and supportive items and services to a Terminally Ill Member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a hospice provider or by others under arrangements made by a hospice provider, including:

1. Nursing services;
2. Physical or occupational therapy, or speech-language pathology;
3. Medical social services under the direction of a physician;
4. Home health aide and homemaker services;
5. Medical supplies and appliances;
6. Drugs and biologicals;
7. Physician Services;
8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility;
9. Counseling, including bereavement, dietary and spiritual counseling;
10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of Crisis and only as necessary to maintain the Terminally Ill Member at home;
11. Inpatient Respite Care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility; and
12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

Hospice Provider: A public agency or private organization, or a subdivision thereof, or a facility which:

1. Is primarily engaged in providing the items and services described in Title 22, California Code of Regulations, Section 51180 to terminally ill Members;
2. Makes such services available as needed on a 24-hour basis, and
3. Provides bereavement counseling for the immediate family and significant others.

Hospital Budget Capitation Allocation: The amount equal to the Hospital Risk Pool Capitation (PMPM) set forth in the contract multiplied by the number of Members assigned to the Shared Risk Physician.

Hospital Risk Pool Arrangements: A risk arrangement contractually required by CalOptima Health between a physician and hospital partner funded by hospital capitation dollars paid by CalOptima Health.

Hospital Services: Covered Services provided in an acute care hospital, long term acute care facility, or rehabilitation hospital.

Hours of Service: The program hours for the provision of CBAS, which shall be no less than four (4) hours, excluding transportation.

Immediate Corrective Action Plan (ICAP): The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Implementation Period: The period of time in which CalOptima Health is undertaking any readiness requirements required by DHCS before performance of the Contract begins. The Implementation Period begins with DHCS awarding the DHCS contract and extends to the effective date that begins the Operations Period.

Incentive Arrangement: Any payment mechanism approved by CMS in accordance with the requirements of 42 CFR section 438.6(b) under which CalOptima Health may receive incentive payments in addition to Capitation Payments for meeting targets specified in accordance the with DHCS contract, including but not limited to Exhibit B, Subsection 1.14.C (*Special Contract Provisions Related to Payment*).

Incurred and Unreported Claim Estimate: A financial accounting of all services that have been performed, but have not been invoiced or recorded, or estimates of costs for medical services provided for which a claim has not yet been filed.

Incurred But Not Reported (IBNR): An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.

Independent Medical Review (IMR): a review of CalOptima Health's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on CalOptima Health but not the Member who may still request a State Hearing after an IMR pursuant to H&S section 1374.30 and 28 CCR section 1300.74.30.

Independent Pharmacy: One (1) or more licensed retail Pharmacies operated under a single business name or multiple business names, or which may be linked under a unique marketing logo or name, but which operate independently of each other as shown by an absence of a uniform set of operating policies and procedures covering all aspects of their operation, and which may or may not be organized under a single ownership and management structure, including franchises.

Indian Health Care Provider (IHCP): A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC section 1603.

Indian Health Service (IHS): An agency within the United States Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for these populations and provides them with a comprehensive Indian health care delivery system.

Indian Health Services Facility: Facilities operated with funds from the Indian Health Service (HIS) under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

Indian Health Services Memorandum of Agreement Provider (IHS/MOA): An Indian Health Service (IHS) program funded under the authority of Public Law 93-638 at 25 USC sections 5301 et seq. These programs have elected to participate in Medi-Cal as IHS/MOA providers. IHS/MOAs are subject to the payment terms of DHCS All Plan Letter (APL) 17-020, The list of eligible IHS/MOA providers is found in DHCS APL 17-020, Attachment #1. These providers receive a federally established All-Inclusive Rate that is updated annually by the federal Office of Management and Budgets and published in DHCS APL 17-020, Attachment #2.

Individual Care Plan (ICP): A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

Individual Contact: One-on-one interactive learning for a specific educational purpose utilizing materials or presentations.

Individual Family Service Plan: A written plan for providing early intervention services to a child eligible under the Individual with Disability Education Act (IDEA) and the child's family. The IFSP enables the family and service provider(s) to work together as equal partners in determining the early intervention services that are required for the child with disabilities and the family.

Individual Housing & Tenancy Sustaining Services: Services that support Members in being successful tenants in their housing arrangement, thus able to sustain tenancy, and are further described in the Centers for Medicaid & CHIP Services (CMCS) informational bulletin titled "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," dated June 26, 2015.

Individual Housing Transition Services: Services that support a Member's ability to prepare for and transition to housing and are further described in the Centers for Medicaid & CHIP Services (CMCS) informational bulletin titled, "Coverage of Housing Related Activities and Services for Individuals with Disabilities," dated June 26, 2015.

Individual Nurse Providers (INP): A Medi-Cal enrolled registered nurse (RN) or licensed vocational nurse (LVN) who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.

Individualized Education Plan (IEP): A written document for an individual with exceptional needs that is developed, reviewed, and revised in a meeting in accordance with Sections 300.320 to 300.328, inclusive, of Title 34 of the Code of Federal Regulations and California Education Code, Title 2, Division 4, Part 30. It also means "individualized family service plan" as described in Section 1436 of Title 20 of the United States Code if the individualized education program pertains to an individual with exceptional needs younger than three (3) years of age.

Individualized Plan of Care (IPC): A written plan designed to provide a Member, determined to be eligible for CBAS with appropriate treatment, in accordance with the assessed needs of the Member.

In-Home Supportive Services (IHSS): Services provided to Members by a county in accordance with the requirements set forth in W&I Code sections 12300 et seq., 14132.95, 14132.952, and 14132.956.

Initial Full Scope Site Review: The first onsite inspection of a PCP site that has not previously had a Full Scope Site Review, or a PCP site that is returning to the Medi-Cal managed care program and has not had a passing Full Scope Site Review within the past three (3) years.

Initial Health Appointment (IHA): Previously called Initial Health Assessment, is an assessment required to be completed within 120 days of MCP enrollment for new members and must include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.

Inquiry: A request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes.

Institution: A facility that meets Medicare's definition of a skilled nursing facility, such as a nursing home and any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 1902(q)(1)(B) of the Social Security Act. Institution does not include assisted or adult living facilities, or residential homes.

Instrumental Activities of Daily Living (IADL): Those activities that allow a Member to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within the Member's community.

Intellectual/Developmental Disabilities (I/DD): A person with an "Intellectual or Developmental Disability" shall have a disability that begins before the individual reaches age 18 and that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, autism, Down syndrome, and other disabling conditions as defined in Section 4512 of the California WIC.

Intellectual Disability (ID): A condition manifested before the person reaches age twenty-two (22) and results in impairment of general intellectual functioning or adaptive behavior and significant limitations in at least three (3) or more of the following areas: communication, self-care, home living, social skills, use of community resources, self-direction, understanding and use of language, learning, mobility, capacity for independent living.

Interdisciplinary Care Team (ICT): A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).

Intermediate Care Facility (ICF): A health facility that meets the standards specified in 22 CCR section 51212 and provides inpatient care to ambulatory or non – ambulatory patients who have recurring need for skilling nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

Intermediate Care Facility/Developmentally Disabled (ICF/DD): A facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services An Intermediate Care Facility/Developmentally Disabled (ICF/DD) includes the following types:

A. ICF/DD – Habilitative as defined in Health and Safety Code (H&S) section 1250(e);
B. ICF/DD – Nursing as defined in H&S section 1250(h); and
C. ICF/DD for purposes of CalOptima Health's contract with DHCS does not include the ICF/DD – Continuous Nursing Care Program.

Intermediate Care Facility/Developmentally Disabled – Habilitative (ICF/DD-H): A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

Intermediate Care Facility/Developmentally Disabled – Nursing (ICF/DD-N): A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.

International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10): The set of diagnosis codes used in the healthcare industry to define a patient's disease state or health status.

Internet Pharmacy: A licensed Pharmacy that accepts prescription requests and conducts the majority of its Prescription business through an Internet web site and which distributes the Prescription medications and supplies for consumer use through the United States (U.S.) mail or by use of other common carrier services.

Interpreter: A person who renders a message spoken in one language into one or more languages. An Interpreter must be qualified per requirements outlined in WIC 14029.91(a)(1)(B) and 45 CFR 92.101(b)(3).

Inter-Rater Reliability: An assessment tool that measures the degree of reliability of different licensed staff when utilizing criteria for authorizing or denying Covered Services.

Intrusion: The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.

Joint Commission (JC): The organization that provides health care accreditation and related services that support performance improvement in health care organization and is composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association.

Justice Involved (JI) Individuals: Individuals who are currently incarcerated, or were formerly incarcerated within the past 12 months.

Kaiser Member: A Member who is enrolled in, or receives all Covered Services, from Kaiser Foundation Health Plan, Incorporated.

Key Personnel: Health network staff, including but not limited to, an officer, executive, administrator, director, or equivalent who has or can be assigned signature authority on behalf of the legal entity; who maintains a fiduciary duty on behalf of the legal entity; and/or who is responsible for plan administration, quality improvement, utilization management, customer service and/or provider relation.

Key Points of Contact: Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.

Known Closure: Occurs when a Member's initial referral loop is completed with an acceptable DHCS defined Known Closure reason code.

Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene): The law that regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340 of the California Health and Safety Code.

Laboratory Testing Site: Any laboratory and any Provider site, such as a Primary Care Provider (PCP) or Specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Lanterman Developmental Disabilities Services Act: The California law that declares that persons with developmental disabilities have the same legal rights and responsibilities guaranteed all other persons by federal and state constitutions and laws, and charges the regional center with advocacy for, and protection of, these rights.

Length of Stay Assignment: CalOptima Health authorizes an inpatient admission and length of stay using nationally recognized, evidence-based criteria as approved by CalOptima Health's Utilization Management (UM) Committee.

Letter of Agreement (LOA): An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.

Letter of Interest: A letter received by CalOptima Health from an entity that is interested in contracting with CalOptima Health to provide services covered under one or more CalOptima Health Programs.

Level I Provider Dispute Resolution (PDR): The process by which a provider submits the initial appeal request to the entity that issued the payment for the claim being disputed.

Level of Care (LOC): Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima Health policies.

Level of Service (LOS): Based on the patient's condition and the needed level of care, used to identify and verify that the patient is receiving care at the appropriate level.

Licensed Midwife: An individual licensed to practice midwifery and assist a woman in normal childbirth as defined in California Business and Professions (B&P) code section 2507.

Life Planning Activities: Items such as wills, living wills or advance directives, and healthcare powers of attorney.

Limited Data Set: Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.

Limited English Proficiency (LEP): An inability or a limited ability to speak, read, write, or understand the English language at a level that permits the Member to interact effectively with Providers or CalOptima Health's employees.

Local Education Agency (LEA): A school district, county office of education, charter school, community college district, California State University or University of California campus.

Local Education Agency (LEA) Specialized Medical Transportation: Medical transportation services provided to an LEA-eligible Member who requires a specially adapted vehicle or use of specialized equipment, including but not limited to lifts, ramps or restraints, to accommodate the LEA-eligible Member's disability.

Local Government Department (LGA): A local governmental entity including, but not limited to, a county child welfare agency, county probation department, county behavioral health department, county social services department, county public health department, school district, or county office of education.

Local Health Department (LHD): A municipal, county, or regional public health department.

Long Term Care (LTC): Specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes.

Long-Term Care Nursing Facility: Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR, Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.

Long Term Care Pharmacy: A licensed Pharmacy that services Members residing in Institutions and meets the following performance and services criteria developed by the Centers for Medicare & Medicaid Services (CMS):

1. Comprehensive inventory and inventory capacity;
2. Pharmacy operations and Prescription orders;
3. Special packaging;
4. Intravenous (IV) medications;
5. Compounding or alternative forms of drug composition;
6. Pharmacist on-call service;
7. Delivery service;
8. Emergency boxes;
9. Emergency log books; and
10. Miscellaneous reports, forms, and Prescription ordering supplies.

Long Term Services and Supports (LTSS): Services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting, and includes both LTC and Home and Community Based Services, and carved-in and carved-out services.

Mail Order Pharmacy: A licensed Pharmacy that accepts prescription requests by U.S. mail or electronic facsimile and that conducts the majority of its prescription business by U.S. mail, and that distributes the majority of its dispensed prescription medications for consumer use by U.S. mail or by use of other common carrier services

Management Services Organization (MSO): A healthcare entity providing management and administrative support service on behalf of the delegated medical group.

Mandated Reporter (MR): Any CalOptima Health employee who, during the normal course of executing his or her assigned duties, interacts with Children, Elder or Dependent Adult Members.

Market Withdrawals: A manufacturer's removal or correction of a distributed product that involves a minor violation which would not be subject to legal action by the Food and Drug Administration (FDA).

Marketing: Any activity conducted by or on behalf of CalOptima Health where information regarding the services offered by CalOptima Health is disseminated in order to persuade or influence eligible beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima Health.

Marketing (HIPAA): Has the meaning given such term in Title 45, Code of Federal Regulations, Section 164.501.

1. Except as provided in paragraph (2) of this definition, marketing means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.
2. Marketing does not include a communication made:
    a. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the covered entity in exchange for making the communication is reasonably related to the covered entity's cost of making the communication.
    b. For the following treatment and health care operations purposes, except where the covered receives financial remuneration in exchange for making the communication:
        i. For treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual;
        ii. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or
        iii. For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.

Marketing Materials: Materials produced in any medium, by or on behalf of CalOptima Health that can be reasonably interpreted as Marketing to Potential Members. Marketing Materials include, but are not limited to, all printed materials, illustrated materials, digital materials, videos, and media scripts.

Marketing Representative: A person who is engaged in Marketing activities on behalf of CalOptima Health.

Medi-Cal Eligibility Data System (MEDS): The automated eligibility information processing system operated by DHCS which provides on-line access for Medi-Cal recipient information and update of Medi-Cal recipient eligibility data.

Medi-Cal Fee-For-Service (FFS) Fee Schedule: The fee schedule used by the Department of Health Care Services (DHCS) to reimburse Medi-Cal Fee-For-Service Providers.

Medi-Cal Fee-For-Service (FFS) Rate: The rate that DHCS pays Providers on a per unit or per procedure billing code basis.

Medi-Cal Managed Care Plan (MCP): A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.

Medical Home: A model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Medically Fragile Persons (Targeted Case Management Services program): Those persons who require ongoing or intermittent medical supervision without which their health status would deteriorate to an acute episode.

Medically Necessary or Medical Necessity: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Medi-Cal Managed Care Accountability Set (MCAS): A set of quality and equity performance measures selected by DHCS for the evaluation of health plan performance that CalOptima Health is required to submit to the Department of Health Care Services (DHCS) annually.

Medi-Cal Provider Manual: The multi-part document identifying Medi-Cal benefits and billing codes published and maintained by DHCS at https://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.aspx.

Medical Loss Ratio (MLR): The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.

Medi-Cal Managed Care Plan: A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.

Medi-Cal Provider: A licensed provider registered with the State of California Department of Health Care Services (DHCS) who accepts Medi-Cal beneficiaries that provide willful disclosure of their active or pending Medi-Cal eligibility.

Medical Record: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.

Medical Record Review (MRR): A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.

Medical Record Survey: The DHCS survey tool for review of medical records for, among other things, format, legal documentation practices, documented evidence of the provision of preventive care, and coordination of primary care services included in the Full Scope Site Review.

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.

Member (Global): An individual enrolled in a CalOptima Health program.

Member Advisory Committee (MAC): A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.

Member Assignment: The written notification and assignment of a Potential Member to the Medi-Cal managed care health plan of the Member's choice, or if as designated by DHCS when the Potential Member fails to make a timely choice.

Member Handbook or Evidence of Coverage (EOC): The document that describes the health care benefits and Covered Services that are available to a Member.

Member Handbook Supplement: A supplement to the CalOptima Health Member Handbook that is prepared and distributed by the Health Network and CHCN, contains general information about the Health Network and CHCN and includes specific information on how to access Covered Services provided by the Health Network and CHCN.

Member Information: Documents that are vital, or critical to obtaining benefits or services, and includes, but is not limited to: the Member Handbook, Provider Directory, welcome packets, Marketing information, form letters including Notice Of Actions (NOA), notices related to Grievances or Appeals, including Grievance and Appeal acknowledgement and resolution letters, CalOptima Health's preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

Member Risk Score: A measurement of a Member's health status according to a minimum of (1) diagnostic code.

Member Survey: A data collection tool utilized to obtain ideas and opinions from Members on certain topics.

Memorandum of Understanding (MOU): A formal written agreement between CalOptima Health and local government agencies, county programs, and third-party entities.

Mental Health Plan (MHP): Pursuant to California Code of Regulations, Title 9 section 1810.226, a MHP is an entity that enters into a contract with DHCS to provide directly, or arrange and pay, for Medi-Cal Specialty

Mental Health Services. A MHP may be a county, counties acting jointly or another governmental or non-governmental entity.

Mental Illness: Member must meet criteria for "Serious Mental Illness (SMI). Member must have any one (1) diagnosis of the following major mental illness within the last two (2) years: one or more of the following diagnosis:

1. Schizophrenia;
2. Paranoia;
3. Mood Disorder and depressive disorders;
4. Panic or other severe anxiety disorders;
5. Somatoform Disorders;
6. Factitious Disorders;
7. Personality disorders;
8. Other psychotic disorders;
9. Other mental disorders that may lead to a chronic disability.
    a. Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia, unless the primary diagnosis is a major mental disorder.

Methadone Detoxification: The administering or furnishing by a physician, or under the ongoing supervision of a physician, either of the following:

1. Methadone as a substitute narcotic drug in decreasing doses to reach a diminished or drug free state in a period not to exceed twenty-one (21) days; or
2. Non-narcotic drugs to reduce or eliminate, over a period not to exceed twenty-one (21) days, an individual's dependence on heroin or other morphine-like drugs.

Mid-Level Practitioner: A non-physician practitioner who has a professional license and certification. They include but are not limited to Certified Nurse Midwives, Certified Nurse Practitioners, and Physician Assistants.

Minimum Fee Payment: A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.

Minimum Necessary: The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Minimum Performance Level (MPL): CalOptima Health's minimum performance requirements for select Quality Performance Measures.

Minor Consent Services: Those Covered Services of a sensitive nature which minor Members under 18 years of age may, without parental or guardian consent, receive, if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services. Minor consent services include, but are not limited to the following situations:

Under Age 12

1. Pregnancy and pregnancy related services
2. Family planning services
3. Sexual assault services

Age 12 and Older

4. Pregnancy and pregnancy related services
5. Family planning services
6. Sexual assault services
7. Infectious, contagious, or communicable disease diagnosis and treatment
8. Sexually transmitted diseases (or infections) prevention, diagnosis and treatment
9. Drug and alcohol abuse treatment and counseling
10. Outpatient mental health treatment and counseling if the opinion of the attending professional person determines that the minor is mature enough to participate intelligently in their health care pursuant to Family Code section 6924.
11. Intimate partner violence services.

Model of Care (MOC): CalOptima Health's approach for providing Enhanced Care Management (ECM) and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.

Monitoring: An on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.

Multipurpose Senior Services Program (MSSP): The Waiver program that provides social and health care management to a Member who is sixty-five (65) years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.

Narcotic Treatment Program: An outpatient service using methadone and/or Levo-Alpha-Acetylmethadol (LAAM), directed at stabilization and rehabilitation of persons who are opiate addicted and have a substance use disorder diagnosis.

National Cancer Institute (NCI) Community Oncology Research Program (NCORP): A cancer center that has received an approved grant from NCI through NCORP that provides cancer clinical trials and care delivery studies.

National Committee for Quality Assurance (NCQA): An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.

National Provider Identifier (NPI): A unique identification number for Providers. CalOptima Health must use the NPIs in the administrative and financial transactions adopted under HIPAA.

Network: Any Provider or entity that has a Network Provider Agreement with CalOptima Health, CalOptima Health's Subcontractor, or CalOptima Health s Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under the Department of Health Care Services contract for Medi-Cal. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider: Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement: A written agreement between a Network Provider and CalOptima Health, Subcontractor, or Downstream Subcontractor.

Network Provider Data: Information concerning all Network Providers in a Network, regardless of location, which render Covered Services to Members in a CalOptima Health's Service Area and the provider groups, Subcontractors, and/or Downstream Subcontractors, if any, under which a Network Provider renders those services. This includes, but is not limited to, information about the contractual relationship between Network Providers, provider groups, Subcontractors, and Downstream Subcontractors within the Network, information regarding the facilities where services are rendered, and information about a Network Provider's area(s) of specialization.

New Admission: Shall mean a Member with no previous residence history at a Facility or one who has had a previous residence history at a Facility but was appropriately discharged as part of the Member's plan of care.

New Technology: An advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Members.

No Wrong Door: Members receive timely Behavioral Health Services without delay, regardless of delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption. This includes concurrent service provision, whereby CalOptima Health must cover Medically Necessary Non-Specialty Mental Health Services (NSMHS) for a Member concurrently receiving Specialty Mental Health Services (SMHS) covered by the county Mental Health Plan (MHP), and ensure those services are coordinated and not duplicative. CalOptima Health must ensure compliance with No Wrong Door pursuant to W&I Code section 14184.402.

Non-Clean Claim: A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Non-clean claim shall have the same meaning as incomplete claim submission.

Non-Contracted Ancillary Service Provider: An Ancillary Services Provider that has not entered into a CalOptima Health Ancillary Services Contract.

Non-Contracted Hospital: A hospital that has not executed a CalOptima Health Hospital Services Contract.

Non-Contracted Provider: A Provider who is not obligated by written contract to provide Covered Services to a Member.

Non-Covered Medical Services: Medical services rendered by a non-Medi-Cal provider; or Medical services in the following categories of services for which:

1. An authorization request must be submitted and approved before CalOptima Health will pay; or
2. An authorization request is not submitted, or an authorization request is submitted but is denied by CalOptima Health because the service is not considered medically necessary.

Non-Emergency Medical Transportation (NEMT): Ambulance, litter van, wheelchair van, and air medical transportation services. NEMT is used when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, and pursuant to 22 CCR sections 51323, 51231.1, and 51231.2, is rendered by licensed Providers.

Non-Experimental Procedure: A procedure accepted by the Department of Health Care Services (DHCS) as non-experimental.

Non-Medical Transportation (NMT): Transportation of Members to obtain Covered Services or Excluded Services by passenger car, taxicabs, or other forms of public or private conveyances, and mileage reimbursement when conveyance is in a private vehicle arranged by the Member and not through a

transportation broker, bus passes, taxi vouchers, or train tickets. NMT does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances, or regulations.

Non-Monetary Member Incentive: A Non-Monetary Member Incentive may include: An item, as approved by DHCS, that promotes good health practices, including but not limited to a gift, gift card, or gift certificate that cannot be redeemed for cash; tickets to a local event, movies, sporting event, concert, play, or amusement park; a product or merchandise that promotes or is associated with good health practices; transportation assistance such as a voucher for public transportation or taxi service; enrollment or membership fees for a program that promotes good health practices, such as a weight management or physical activity program; or raffle for an item that promotes good health practices as approved by DHCS.

Non-Physician Medical Practitioner (NMP): A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.

Non-Specialty Mental Health Services (NSMHS): All of the following services that CalOptima Health must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice:

1. Mental health evaluation and treatment, including individual, group and family psychotherapy;
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation; and
5. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

Notice of Action (NOA): A formal letter from CalOptima Health informing a Member of an "Adverse Benefit Determination."

Notice of Appeal Resolution (NAR): A formal letter from CalOptima Health informing a Member of the outcome of the Appeal of an Adverse Benefit Determination. The NAR informs the Member whether CalOptima Health has overturned or upheld its decision on the Adverse Benefit Determination.

Nurse Care Manager: The Nurse Care Manager (NCM): A licensed Register Nurse (RN) responsible for the following activities:

1. Certifying level of care.
2. Conducting assessments and/or reassessments.
3. Collaborating and consulting with the SWCM in the development of the participant’s individualized care plan.
4. Implementing the services detailed in the care plan.
5. Monitoring of participant’s needs and provisions in the care plan.
6. Identifying and developing support systems for the participant.
7. Collaborating with physicians and other health professionals.
8. Ensuring participant record documentation meets program requirements.
9. Ensuring that prior to purchasing and authorizing Waiver Services, all other resources have been exhausted.

Nurse Practitioner: A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforms to board standards as specified in Title 16 CCR section 1484.

Nursing Facility Level A (NF-A): Known as the Immediate Care level. NF-A level of care is characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.

Nursing Facility Level B (NF-B): Known as the Long-Term Care Nursing Facility level. NF-B level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.

Operations Period: The period of time between the effective date of the first month of operations and continues on through the last month of CalOptima Health's capitation and provision of services to Members. The Operations Period commences at the conclusion of the Implementation Period upon DHCS' acceptance of CalOptima Health's completion of any readiness requirements required by DHCS.

Optional Targeted Low-Income Children's Program (OTLICP): The group of Medi-Cal Members that transitioned from the Healthy Families Program into Medi-Cal in 2013, as described in California Welfare & Institutions Code 14005.26.

Orange Blank: Statements, reports, and schedules found in the Health Maintenance Organization (HMO) Annual Reporting Form, revised 1989.

Organizational Providers: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers.

Originating Site: A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.

Other Health Coverage (OHC): Health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements.

Other Risk Arrangements: A risk arrangement between any Health Network partners or Health Network participants outside of a Hospital Risk Pool Arrangement.

Out-of-Network (HN): Outside of the selected Health Network's participating provider network within the Service Area.

Out-of-Network Provider (CalOptima Health): A Provider that does not participate in CalOptima Health's Network.

Overpayment: Any payment made by CalOptima Health to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima Health by DHCS to which CalOptima Health is not entitled to under Title XIX of the Social Security Act.

Over Utilization: Unnecessary health care provided with a higher volume or cost than is appropriate in delivering quality health care services.

Palliative Care: Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Pap Smear: A test for cancer of the cervix.

Parenteral Nutrition: Parenteral nutrition refers to the delivery of calories and nutrients into a vein. This could be as simple as carbohydrate calories delivered as simple sugar in an intravenous solution or all of the required nutrients could be delivered including carbohydrate, protein, fat, electrolytes (for example sodium and potassium), vitamins and trace elements (for example copper and zinc). There are many reasons for enteral and parenteral nutrition including GI disorders such as bowel obstruction, short bowel syndrome, Crohn's disease, and ulcerative colitis; as well as certain cancers or in comatose patients.

Partially Delegated Subcontractor: A Subcontractor that contractually assumes some, but not all, duties and obligations of CalOptima Health under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subcontractors.

Partial Dual-Eligible: A Member who is twenty-one (21) years of age or older and is eligible for Medi-Cal, and who is also eligible for benefits under either Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

Participating Pharmacy: Any pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing pharmacy services to Members.

Participating Pharmacy Agreement: The contract between the PBM and a Participating Pharmacy that provides Pharmaceutical Services to Members.

Participating Pharmacy Network: The Pharmacies that are authorized by the PBM to provide Pharmaceutical Services to Members, as set forth in CalOptima Health's list of Participating Pharmacies.

PASRR Level I Screening: A screening completed by a nursing facility for each resident that is going to be admitted to a Medicaid certified nursing facility. The purpose of the Level I screening is to identify a resident who has a mental illness or is suspected of having mental illness, an intellectual/developmental disability, or a related condition to determine if specialized services are needed during their stay in a nursing facility.

PASRR Level II Evaluation: An evaluation is necessary to ensure that the resident identified with mental illness and/or intellectual disability is residing in a facility that can provide the necessary level of care and specialized services. Federal law requires that DHCS contract with a third-party entity with the capacity to perform detailed clinical Level II evaluations.

Pass-Through Payment: The "Pass-through payment," as defined in 42 CFR section 438.6(a), that has been documented in a rate certification approved by the federal Centers for Medicare and Medicaid Services (CMS).

Pay for Performance (P4P): Pay-for-performance is an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care. These arrangements may provide financial incentives to hospitals, physicians, and other health care providers to carry out such improvements and achieve optimal outcomes for patients.

Payment: Has the meaning in Title 42 of the Code of Federal Regulations, Section 164.501, including: activities carried out by CalOptima Health including:

1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;
2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and
3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Payment Period: Refers to a set interval of time in which CalOptima Health provides payment to Health Networks for Covered Services furnished to Members.

Pediatric Preventative Care Services: Health care services provided to Members under the age of twenty-one (21) that ensure optimal growth and development to achieve full potential as adults.

Pediatric Preventive Services (PPS): Regular preventive health assessments, as recommended by the American Academy of Pediatrics or the Child Health and Disability Prevention (CHDP) Program. These include, but are not limited to, health and developmental history, physical examination, nutritional assessment, immunizations, vision testing, hearing testing, selected laboratory tests, health education, and anticipatory guidance.

Pending State Plan Amendment (SPA): A State Plan Amendment (SPA) to the California Medicaid State Plan (Title XIX of the Social Security Act) for an extension of a Directed Payment program that has been submitted by DHCS to CMS for review and is currently pending approval. A Pending SPA, which has not yet been approved by CMS, may change if required for CMS approval.

Performance Measurement: The regular collection of data to assess whether the correct processes are being performed and desired results are being achieved.

Performance Measures: Development, application and use of performance measures to assess achievement of standards.

Perinatal Support Services (PSS): Perinatal services as defined in the Contract for PSS.

Person-Centered Planning or Person-Centered Plan of Care: An ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences. Person Centered Planning includes consideration of the current and unique bio-psycho-social and medical history of the individual Member, as well as the Member's functional level, support systems and continuum of care needs. Person Centered Planning is an integral part of Basic and Complex Care Management and Discharge Planning.

Personal Health Care Provider: May include a physician assistant or nurse practitioner within their scope of practice under the appropriate supervision of the physician.

Personal Representative: Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.

Personally Identifiable Information (PII): Any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmaceutical Services: Covered drugs and related professional services provided to a Member pursuant to applicable state and federal laws, CalOptima Health's Pharmacy Services Program Manual, and the standard of practice of the pharmacy profession of the state in which the Pharmacy is located.

Pharmacist: A person to whom the State Board of Pharmacy has issued a license, authorizing the person to practice pharmacy.

Pharmacist-In-Charge (PIC): The licensed Pharmacist designated by each Pharmacy in accordance with Title 16, California Code of Regulations, Section 1709.1, who is legally responsible for that Pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

Pharmacy: An area, place, or premises licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed.

Pharmacy Auditors: The entity contracted by CalOptima Health to perform audits of its participating pharmacies, including review of the prescribing records of Prescribing Providers.

Pharmacy Benefit Manager (PBM): The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.

Pharmacy Benefit Manager (PBM) Services Agreement: The written agreement between a PBM and CalOptima Health regarding the delivery and maintenance of the Participating Pharmacy network.

Pharmacy Home Program: A program by which the Member selects or is assigned to a single provider of pharmaceutical services.

Pharmacy Technician: A person who assists a Pharmacist in the performance of Pharmacy-related duties, to whom the State Board of Pharmacy has issued a certificate of registration to act as a Pharmacy Technician.

Phaseout Period: The period of time after the date the Operations Period or Contract extension ends. The Phaseout Period extends until all activities required during the Phaseout Period for each Service Area are fully completed.

Physical Accessibility Review Survey (PARS): A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.

Physician Hospital Consortium (PHC): A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima Health's Contract for Health Care Services.

Physician Medical Group (PMG): A group practice, independent practice association, or other formal business arrangement comprised of individuals, each of whom holds an unrestricted license to practice medicine or osteopathy in the state in which they practice, and which participates with a hospital in a Physician Hospital Consortium (PHC) or holds a shared risk contract with CalOptima Health.

Plan-Do-Study-Act (PDSA): The PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

Plan of Care: An individual written plan of care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).

Point-of-Service (POS) Device: A device that supports verification against the Department of Health Care Services (DHCS) Automated Eligibility Verification System (AEVS) database and provides a hard copy printout of a Member's Medi-Cal eligibility as confirmation.

Polypharmacy: The simultaneous use of multiple medications by a single Member, for one (1) or more conditions.

Population Health Management (PHM): A whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

Population Health Management (PHM) Service (also known as Medi-Cal Connect): A data backed platform that collects and links Medi-Cal beneficiary information from disparate sources and performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.

Population Health Management Strategy (PHMS): An annual deliverable that CalOptima Health must submit to DHCS requiring CalOptima Health to demonstrate that it is responding to identified community needs, to provide other updates on its PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

Population Needs Assessment (PNA): A multi-year process during which CalOptima Health will identify and respond to the needs of its Members and the communities it serves by participating in the Community Health Assessment (CHA) of Local Health Departments (LHDs) in its Service Area. The findings of the PNA/CHA collaboration will inform CalOptima Health's annual PHM Strategy.

Population of Focus (POF): Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS:

1. Adult Populations of Focus include the following:
    a. Individuals and families experiencing Homelessness;
    b. Individuals At Risk for Avoidable Hospital or emergency department utilization;
    c. Adults with Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD);
    d. Individuals transitioning from incarceration;
    e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC);
    f. Nursing facility residents who want to transition to the community; and
    g. Birth Equity Population of Focus.

2. Populations of Focus for Children and Youth include the following:
    a. Children (up to age 21) experiencing Homelessness;
    b. Individuals At Risk for Avoidable Hospital or emergency department utilization;
    c. Children (up to age 21) with Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD);
    d. Individuals transitioning from incarceration;
    e. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition;
    f. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and
    g. Birth Equity Population of Focus.

Post-Payment Recovery (PPR): CalOptima Health's efforts to recover the cost of the services from other third-party payors responsible for the payment of a Member's health care services.

Post-Service Request: A request for coverage of pharmaceutical services that have been received by a Member, e.g., retrospective review.

Post-Stabilization Care Services: Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4 to improve or resolve the Member's condition.

Potential Member: A Medi-Cal beneficiary who resides in CalOptima Health's Service Area and is subject to mandatory Enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the aid codes described in the DHCS Contract for Medi-Cal.

Potential Quality Issue (PQI): Any issue whereby a Member's quality of care may have been compromised. A PQI requires further investigation to determine whether an actual quality issue or opportunity for improvement exists.

Practitioner: A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

Pre-Service Request: A request for coverage of pharmaceutical services that CalOptima Health must approve in advance, in whole or in part.

Precluded or Preclusion: A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Preferred Drug Product: A medication on the Formulary that provides therapeutic effectiveness at the most reasonable cost when more than one therapeutically equivalent product is available on the Formulary approved by the Pharmacy & Therapeutics (P&T) Committee.

Pregnant or Postpartum: A person who is "Pregnant or Postpartum" shall be either currently pregnant or within 12 months postpartum.

Prenatal Care: Health care that a pregnant woman receives from a licensed practitioner. Services needed may include physical examinations, dietary and lifestyle advice.

Prenatal Care Provider: A Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Nurse Practitioner, Physician Assistant (PA), Certified Nurse Midwife or Licensed Midwife who provides prenatal care to a Member under the supervision of a licensed physician.

Prescriber: As defined in the Business and Professions Code, Section 4039, physicians, dentists, optometrists, pharmacists, podiatrists, registered nurses, and physician's assistants authorized by a currently valid and unrevoked license to practice their respective professions in their state.

Prescribing Provider: The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.

Prescription: Oral, written, or electronic transmission order that meets the requirements of the California Business and Professions Code, Chapter 9, Division 2, Article 2 "Definitions", Section 4040 "Prescription: Content Requirements", except any Prescription written by a veterinarian.

Prescription Drug: A drug or medication that can only be accessed through a Provider's prescription.

Preventive Care: Health care designed to prevent disease, illness, injury, and/or its consequences.

Previous MCP: A Prime MCP or Subcontractor MCP that a member is required to leave effective January 1, 2024, for one of the following reasons: (1) the MCP exits the market (i.e., an Exiting MCP), (2) the Subcontractor and the MCP terminate their Subcontractor Agreement, or (3) DHCS requires the Prime MCP to transition members to a Subcontractor MCP.

Primary Care: A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to Specialty Care Provider focusing on specific needs.

Primary Care Physician (PCP) Site: A building, office, suite in a facility, or site in which CalOptima Health PCPs provide medical services to CalOptima Health Members.

Primary Care Practitioner/Physician (PCP): A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

Primary Care Provider (PCP): A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; 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.

Primary Hospital: A hospital contracted with CalOptima Health on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).

Primary Physician Group: A physician group contracted with CalOptima Health on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).

Primary Plan/Payer: Party identified to be responsible for the first level of payment on a claim.

Primary Source Verification: Verbal or written information received directly from the issuing source.

Prior Authorization: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

Private Duty Nursing: An Early Periodic Screening, Detection, and Treatment (EPSDT) Supplemental Service that includes Medically Necessary services provided to Members who require continuous in-home nursing care.

Private Services (PS): Current Procedural Terminology Codes 59840 through 59857 and CMS Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336.

Program: Any of CalOptima Health's programs including the CalOptima Health Medi-Cal Program, OneCare, PACE, or the Multipurpose Senior Services Program.

Program Data: Data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-Network request data, and Primary Care Provider (PCP) assignment data as of the last calendar day of the reporting month.

Program of All-Inclusive Care for the Elderly (PACE): As defined in 42 C.F.R. § 460.6 and authorized under California law at Welfare and Institutions Code section 14591 et seq., PACE is a capitated program for individuals over the age of 55 certified by DHCS for nursing home level of care. PACE organizations cover all Medicare and Medicaid benefits, including medical services and long-term services and support, organizes a comprehensive service delivery system governed by federal regulations, and integrate Medicare and Medicaid financing. PACE is a three-way partnership between the federal Government, California, and the PACE Organizations.

Prospective Payment System (PPS): A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment from CMS is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, FQHCs, RHCs, and Skilled Nursing Facilities.

Protected Health Information (PHI): Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

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.

Provider Advisory Committee (PAC): A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

Provider Directory: CalOptima Health's listing of all Network Providers and that includes the Providers' contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider's office and whether the Provider's office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.

Provider Dispute Resolution Mechanism: CalOptima Health's obligation to include a timely, fair, and cost-effective dispute resolution process where Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers can submit disputes.

Provider Preventable Condition (PPC): A condition occurring in an inpatient hospital setting, or a condition occurring in any health care setting, that meets the criteria as stated in 42 CFR section 447.26(b).

Prudent Layperson: A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.

Psychotherapy Notes: Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. Notes recorded (in any medium) by a health care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the Member's medical record. Psychotherapy Notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the Treatment plan, symptoms, prognosis, and progress to date.

Purchase Records: All of Participating Pharmacy's purchase invoices, periodic statements, and credit or return memos from all sources, and documentation of the Participating Pharmacy's payments for all drug or medical supply acquisitions, including business bank statements, copies of checks, and any other documents required by the PBM or CalOptima Health.

Purchaser: Data from state and federal agencies and category codes used to identify Members for case management.

Quality Achievement Community ReinvestmentThe additional net income that MCPs are required to invest into initiatives in counties where the MCP operates in which they do not meet minimum quality measure performance thresholds for the applicable CY, starting with CY 2024. The MCP Contract requires MCPs to allocate Quality Achievement Community Reinvestment funds equal to 7.5% of its annual net income.

Qualified Autism Service Paraprofessional: An individual who is employed and supervised by a QAS Provider to provide Medically Necessary Behavioral Health Treatment (BHT) services to Members.

Qualified Autism Service Professional: An Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the California Medicaid State Plan, who provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

Qualified Autism Service Provider: A licensed practitioner or Board Certified Behavior Analyst (BCBA) who designs, supervises, or provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

Qualified Family Planning Practitioner: A qualified provider licensed to furnish family planning services within their scope of practice within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish Family Planning Services to a Member as specified in title 22, Code of California Regulations, Section 51200

Qualified Family Planning Provider: A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200. A Physician, Physician Assistant (under the supervision of a Physician), Certified Nurse Midwife, Licensed Midwife and Nurse Practitioner are authorized to dispense medications. Pursuant to California Business and Professions Code section 2725.2, if these contraceptives are dispensed by a Registered Nurse (RN), the RN must have completed required training pursuant to Business and Professions Code section 2725.2 and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier TD (TD modifier as used for RN for (Behavioral Health) as found in the Medi-Cal Provider Manual.

Qualified Health Educator: A qualified health educator is defined as a health educator with one (1) of the following qualifications:

1. Master of Public Health (MPH) degree with a health education or health promotion emphasis; or
2. MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc.

Qualified Provider: A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).

Qualifying Services: Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.

Quality and Performance Improvement Project: A component of a comprehensive quality improvement program that addresses the quality of clinical care as well as the quality of health services delivery. A Quality and Performance Improvement Project is an initiative by the organization to measure its own performance in major focus areas of clinical and non-clinical care. Also known as Quality Improvement Projects (QIPs) and Performance Improvement Projects (PIPs).

Quality and Safety of Clinical Care: Defined as, Quality of physical health care, including primary and specialty care; Quality of Behavioral Health services; Quality of LTSS;

Quality Improvement: Systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.

Quality Improvement Health Equity Committee (QIHEC): A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.

Quality Improvement and Health Equity Transformation Program (QIHETP): The systematic and continuous activities to monitor, evaluate and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the DHCS Contract for Medi-Cal.

Quality Improvement Organization (QIO): An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities

Quality Indicators: Measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcomes of care delivered in that clinical area.

Quality Initiatives: Initiatives that encompass quality improvements projects and other activities that addresses the quality of care and health services delivery of Members. Performance measurements are utilized to assess achievement of standards in focus areas of clinical and non-clinical.

Quality Measure Compliance Audit: A thorough assessment of CalOptima Health's information system capabilities and compliance with each HEDIS® specification to ensure accurate, reliable, and publicly reportable data.

Quality of Care (QOC): The degree to which health services for members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality of Service (QOS): Defined as, adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services; Continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

Quality Performance Measures: Tools that help measure healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Quantitative Treatment Limitation (QTL): A limit on the scope or duration of a Covered Service that is expressed numerically.

Rating Period: A period selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to Centers for Medicare and Medicaid Services (CMS) as required by 42 CFR section 438.7(a).

Readiness Assessment: An assessment conducted by a Review Team prior to the effective date of a Health Network's, or other contracted entity's, Contract with CalOptima Health of the Health Networks, or contracted entity's, compliance with all or a specified number of operational functional areas as determined by CalOptima Health.

Receiving Health Network: A Health Network to which a Member is transitioning.

Reconstructive Surgery: Surgery performed to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

1. To improve function; and
2. To create a normal appearance, to the extent possible.

In the case of transgender members, gender dysphoria is treated as a "developmental abnormality" for purposes of the reconstructive statute and "normal" appearance is to be determined by referencing the gender with which the Member identifies.

Records (Pharmacy): All physical and electronic records of drug and medical devise acquisition from and disposition to all persons and entities including, but not limited to drug wholesalers, drug manufacturers and distributors, other Pharmacies and Members, and any other document related to the terms of the PPA. Such Records include but are not limited to license and credentialing records, claims transaction records, Purchase Records, Prescriptions (including all physical and electronic notations related to every Prescription), all Member signature logs, records of payments for drug and device acquisitions, and remittance advice records from the PBM.

Recredentialing: The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.

Referral: The process of a Provider directing a Member to another Provider for care and or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.

Regional Center (RC): A non-profit, community-based entity that is contracted by the Department of Developmental Services (DDS) and develops, purchases and manages services for Members with Developmental Disabilities and their families.

Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and:

1. Performs some of the Medicare Advantage organization's management functions under contract or delegation;
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

Remittance Advice Detail (RAD): A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.

Report Grid: A matrix of reports required by CalOptima Health, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats.

Report Template: A blank form of each report also including instructions and file layout and/or data dictionary.

Reproductive Health Care: Has the meaning in Title 45 (Code of Federal Regulations) CFR, Section 160.103, including the following: health care, as defined at Title 45 CFR, Section 160.103, that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes.

Required by Law: Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law, and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.

Research: Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Resolution: The grievance has reached a final conclusion with respect to the Member or Provider’s submitted Grievance.

Respite Care: Hospice Care provided through short-term, inpatient care in an acute hospital, skilled nursing facility/Level B, intermediate care facility/Level A, or a hospice facility which is organized to provide inpatient care directly, when necessary to relieve family Members or others primarily caring for the Member.

Restricted Provider Database (RPD): The database maintained by DHCS that lists Providers who are placed under a Medi-Cal payment suspension while under investigation based upon a credible allegation of Fraud, or Providers who are placed on a temporary or indefinite Medi-Cal suspension while under investigation for Fraud or Abuse, or Enrollment violations.

Retail Pharmacy: A Pharmacy open for business to the general public, excluding Mail Order Pharmacies and Internet Pharmacies.

Retaliation: Includes, but not limited to, coercion, threats, intimidation, discrimination, and other forms of retaliatory action against individuals.

Retroactive Eligibility: Eligibility for Medi-Cal and the CalOptima Health program established retrospectively by the County of Orange Social Services Agency.

Retroactive Ineligibility Determination: A determination by DHCS that a Member's eligibility was improperly granted (*e.g.,* the individual did not meet eligibility criteria or there was an error resulting in an individual being granted eligibility more than once under different CINs) such that the Member was not entitled to receive Medi-Cal program benefits.

Retroactive Terminations of Eligibility: A determination by DHCS that a Member who once was eligible is, as of a specified date in the past, no longer eligible for Medi-Cal program benefits.

Retrospective Review: The process of determining Medical Necessity after treatment has been given.

Review Panel: The panel authorized to review Provider Complaints pursuant to CalOptima Health Policy HH.1101 Provider Complaint.

Risk Assignment Database: A database that contains Members' diagnostic and medical information as reported on the facility and professional Encounter data submitted by a Health Network in accordance with CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements, and claims data collected by CalOptima Health for CalOptima Health Direct and Shared Risk Groups.

Risk Bearing Organization (RBO): A professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, or another lawfully organized group of physicians that:

1. Delivers, furnishes, or otherwise arranges for or provides health care services; and
2. Does all the following:
    a. Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees;
    b. Receives compensation for those services on a capitated or fixed periodic payment basis; and
    c. Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation payment made by the plan to the risk bearing organization.

Risk Sharing Mechanism: Any payment arrangement, such as reinsurance, risk corridors, or stop-loss limits, documented in the Centers for Medicare and Medicaid Services (CMS) approved rate certification documents for the applicable Rating Period prior to the start of the Rating Period, that is developed in accordance with 42 CFR section 438.4, the rate development standards in 42 CFR section 438.5, and generally accepted actuarial principles and practices.

Risk Stratification: A systematic process for identifying and predicting Member risk levels relating to health care needs, services, and coordination.

Risk Stratification and Segmentation (RSS): The process of separating member populations into different risk groups and/or meaningful subsets using information collected through population assessments and other data sources. RSS results in the categorization of members with care needs at all levels and intensities.

Risk Tiering: The assigning of members to standard risk tiers (i.e., high, medium-rising, or low), with the goal of determining appropriate care management programs or specific services.

Routine Care: Covered Services that are not urgent in nature and may be pre-planned or scheduled in advance.

Routine Home Care: Hospice Care provided in the Member's residence which is not Continuous Home Care.

Routine Physical Exams: A well-care visit that usually emphasizes priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Rural Health Clinic (RHC): An entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.

Safety Net Hospital: A hospital providing acute inpatient services to eligible Members. Safety Net Hospitals include governmental–operated health systems, disproportionate share hospitals, public and university hospitals, and children's hospitals.

Safety Net Provider: Any Provider of comprehensive Primary Care or acute hospital inpatient services that provides services to a significant number of Medi-Cal recipients, receive charity, and/or are medically underinsured, in relation to the total number of patients served by the Provider.

Sanction: An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

Scheduled Elective Surgeries: 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.

School Site: A facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. "School Site" also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of Medically Necessary treatment of a mental health or Substance Use Disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

Screening: A brief process or questionnaire for examining the possible presence of a particular risk factor or problem to determine whether a more in-depth assessment is needed in a specific area of concern.

Screening, Brief Intervention, Referral and Treatment (SABIRT): Comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUDs), as well as those who are at risk of developing SUDs.

Seating and Positioning Components (SPC): Seat, back and positioning equipment mounted to the Wheelchair base.

Seating Clinic: A CalOptima Health contracted utilization management evaluation by a multidisciplinary team led by a principal therapist to evaluate a Member's needs for a Custom Seating System, recommend the most appropriate Custom Seating System, fit the Custom Seating System, and Report UM activity.

Secondary Plan: Responsible party for the Medically Necessary covered items or services under the secondary health coverage which are not reimbursed under the primary plan/payer. Payment also includes the fee payable by the Member at the time of service known as deductibles or co-payments.

Security Incident: Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Seniors and Persons with Disabilities (SPD): Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

Sensitive Services: All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner

violence, and includes services described in Family Code, Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930, and Health and Safety Code, Sections 121020 and 124260, obtained by a patient at or above the minimum age specified for consenting to the service, in accordance with California Civil Code, Section 56.05(s).

Serious Chronic Condition: A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that either:

1. Persists without full cure or worsens over an extended period, or
2. Requires ongoing treatment to maintain remission or to prevent deterioration.

Serious Emotional Disturbance (SED): Persons from birth up to age 18, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills.

Serious Mental Illness (SMI): Persons, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. Major life activities include activities of daily living (e.g., eating, bathing, dressing), instrumental activities of daily living (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication), and functioning in social, family, and vocational/educational contexts.

Service Area: The county or counties that CalOptima Health is approved to operate in under the terms of the DHCS contract. Currently, this covers Orange County, California.

Service Authorization Request: A request by a Member or a Member's Provider for the provision of a Covered Service.

Service Location: The location where a Member obtains Covered Services under the terms of this Contract.

Severity Level 1 Drug Interactions: Drug combinations that are clearly contraindicated in all cases and should not be dispensed or administered concurrently to the same recipient. A manufacturer's label indicating the contraindication is sufficient to warrant withholding certain drug combinations, including a drug combination in this category, regardless of clinical evidence or lack thereof.

Share of Cost: The amount of health care expenses that a recipient must pay for each month before they become eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.

Shared Risk Budget: The total amount that CalOptima Health allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.

Shared Risk Expenses: Includes:

1. Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;
2. An estimate of Incurred but Not Reported (IBNR) expenses;
3. Administrative expenses at a rate established in the Contract for Health Care Services; and
4. Any reinsurance premiums paid by CalOptima Health allocable to the Shared Risk Group.

Shared Risk Group (SRG): A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.

Shared Risk Pool: The risk sharing program, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima Health and Physician.

Significant Change: Changes in Covered Services, benefits, geographic Service Area, composition of payments to its Network, or Enrollment of a new population.

Site Administrator: A User at the Provider's office designated to:

1. Control CalOptima Health Link access;
2. Is the point of contact to CalOptima Health; and
3. Has the authority to provide and terminate access to authorized staff at the Provider's office.

Site Review: Surveys and reviews conducted by DHCS or CalOptima Health to ensure that Network Provider, Subcontractor, and Downstream Subcontractor sites have sufficient capacity to provide appropriate health care services, carry out processes that support continuity and coordination of care, maintain Member safety standards and practices, and operate in compliance with all applicable federal, State, and local laws and regulations.

Site Review Survey: The DHCS survey tool for onsite Full Scope Site Reviews.

Skilled Nursing Care: Covered Services provided by nurses, technicians, and/or therapists during a stay in a Skilled Nursing Facility or in a Member's home.

Skilled Nursing Facility (SNF): Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

Social Drivers of Health (SDOH): The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.

Social Needs: Non-clinical needs relating to institutions or functioning of humans in society to meet basic needs such as relationships, mental health status, or the needs for food and shelter.

Solid Organ Transplant: A Transplant for:

1. Heart;
2. Heart and lung;
3. Lung;
4. Liver;
5. Small bowel;
6. Kidney;
7. Combined liver and kidney;
8. Combined liver and small bowel; or
9. Combined kidney and pancreas

Special Care Center: A center that provides comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions.

Special Health Care Needs: A Member who meets at least one of the following criteria:

1. Medicare eligible;
2. Diagnosed with an emotional or physical disability;
3. Placed in the foster care system;
4. Regional Center of Orange County (RCOC) program eligible; or
5. CCS program eligible.

Specialist: A Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in W&I section 14197.

Specialized (or 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.

Specialty Care Provider (SCP): Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.

Specialty Mental Health Provider: A person or entity who is licensed, certified, otherwise recognized, or authorized under the California law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Services: A Medi-Cal covered mental health service provided or arranged by county mental health plans for Members in their counties that need Medically Necessary specialty mental health services.

Specialty Program: A Medi-Cal program (such as Whole Child Model or Health Homes) that may be offered by only select contracted health networks.

Standards of Care: A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance conforming to an established rule that is approved and monitored for compliance by an authoritative agency or professional.

Standing Referral: A referral by a Primary Care Provider (PCP) to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the Primary Care Provider having to provide a specific referral for each visit.

State: The state of California.

State Hearing: A hearing with an Administrative Law Judge to resolve a Member's dispute about an action taken by CalOptima Health, its Network Providers, Subcontractors, or Downstream Subcontractors.

State of California Beneficiary Eligibility Verification System: A system maintained by the Department of Health Care Services (DHCS) that provides up-to-date information regarding current and retroactive Medi-Cal eligibility.

State Supported Services: Private Services as defined and described in the companion to CalOptima Health's Primary Contract with Department of Health Care Services (DHCS), and Covered Services, as identified in CalOptima Health's Primary Contract with DHCS, for UIS Members with the exception of pregnancy-related services for UIS Members and emergency services as they are described in CalOptima Health's Primary Contract with DHCS.

Status 7: Temporarily unsuitable for Transplant according to the DHCS-approved Transplant Center.

Step Therapy: A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a Member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.

Sterilization: Surgical procedure that results in infertility.

Street Medicine: A set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. The fundamental approach of Street Medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Street Medicine utilizes a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address Social Drivers of Health that impede health care access.

Street Medicine Provider: A Provider that renders Street Medicine services as offered by CalOptima Health to its Members. Street Medicine Providers may provide services in various roles, such as the Member's assigned Primary Care Provider (PCP), through a direct contract with CalOptima Health, as an Enhanced Care Managed (ECM) Provider, as a Community Supports Provider, or as a referring or treating contracted Provider as set forth in DHCS APL 24-001: Street Medicine Provider: Definitions and Participation in Managed Care.

Subacute Care: A level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed Skilled Nursing Care than is provided to the majority of Members in a Skilled Nursing Facility (SNF), as defined in 22 CCR section 51124.5.

Subacute Facility – Adult: A health facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.

Subacute Facility – Pediatric: A health facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

Sub-Contracting: A written agreement entered into by CalOptima Health with any of the following:

1. A provider of health care services who agrees to furnish Covered Services to Members.
2. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS.

Subcontractor: An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement: A written agreement between CalOptima Health or CalOptima Health's Subcontractor and a Subcontractor. The Subcontractor Agreement must include a delegation of CalOptima Health's duties and obligations under the DHCS Contract for Medi-Cal.

Subcontractor Network: An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Sub-Delegate: An entity that has entered into a written agreement with a Health Network or other delegated Provider to perform certain operational functions that would otherwise be required to be performed by CalOptima Health, the Health Network or other delegated Provider, in order to meet contractual and/or regulatory obligations. Examples of a Sub-Delegate may include, but are not limited to, a management services organization (MSO) or a credentials verification organization (CVO).

Sub-delegation: The process by which a Health Network expressly grants, by a formal agreement, to a sub-delegated entity the authority to carry out a function that would otherwise be required to be performed by the Health Network in order to meet its obligations under the Health Network Service Agreement.

Substance Use Disorder (SUD): Those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Supervising Provider: A licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

Supplemental Payment: A payment, in addition to the Capitation Payment made by DHCS to CalOptima Health in accordance with the DHCS Contract for Medi-Cal.

Surgical Supply: Supply indicated by the ZM/ZN modifier in a claim.

Suspended/Ineligible Provider List: The list containing the names of former Medi-Cal Providers suspended from or ineligible for participation in the Medi-Cal program. The Suspended and Ineligible Provider List is available online on the DHCS website.

Synchronous Interaction: A real-time interaction between a Member and a health care provider located at a Distant Site.

Targeted Case Management (TCM): Services which assist Members within specified target groups to gain access to needed medical, social, educational and other services, as set forth in 42 USC section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.

Technology Dependent Persons (Targeted Case Management Services program): Those persons who use a medical technology, embodied in a medical device, that compensates for the loss of normal use of a vital body function and require skilled nursing care to avert death or further disability.

Telehealth: A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.

Telephone Triage: Telephonic assessment of patient complaints or problems that may be performed by licensed personnel in accordance with established standards of practice.

Template Data: Data reports submitted to DHCS by CalOptima Health, which includes but is not limited to, data of Member populations, health care benefit categories, or program initiatives.

Terminal Illness: An incurable or irreversible condition that has a high probability of causing death within one year or less.

Terminally Ill: A medical prognosis certified by a physician is that a Member's life expectancy is six (6) months or less if the Terminal Illness runs its normal course.

Tertiary Care: Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.

Tertiary/Children's Hospital: An acute care hospital that is either:

1. A Children's Hospital as defined in Welfare and Institutions Code, Section 10727; or
2. A Level I or Level II Trauma Center as designated by the California Emergency Medical Services Authority.

Third Party Administrator (TPA): An individual or entity that has a written agreement with CalOptima Health to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.

Third Party Administrator (TPA) Agreement: A contract between a TPA and a Provider for the provision of Covered Services to Members.

Third Party Tort Liability (TPTL): The contractual responsibility or tort liability of an individual or entity other than Contractor or the Member for the payment of claims for injuries, or trauma sustained by a Member.

Threshold Languages/Threshold or Concentration Standard Languages: The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.

Transgender: A person whose gender does not correspond to that person's biological sex assigned at birth.

Transgender Services: The treatment of the gender identify disorder which may include, but is not limited to, psychotherapy, continuous hormonal therapy, laboratory testing to monitor hormone therapy, and gender reassignment surgery that is not cosmetic in nature.

Transitional Care Services (TCS): Services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).

Transition of Care: The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Transjugular Intrahepatic Portosystemic Shunt (TIPS): A surgically created connection within the liver between the portal and systemic circulations. A TIPS is placed to reduce portal pressure in patients with complications related to portal hypertension.

Transplant: A Non-Experimental Procedure for human tissue, blood, or organ Transplant.

Transplant Center Hold: Temporarily unsuitable for the evaluation process according to the DHCS-approved Transplant Center.

Transplant Packet: All clinical information related to the evaluation process of a Member who has completed his or her Transplant work-up.

Treatment: Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

Treatment Authorization Request (TAR): Certain Fee-for-Service (FFS) procedures and services that are subject to authorization by Medi-Cal field offices before reimbursement can be approved.

Triage and Screening Services: Assessment of a Member's health concerns and symptoms via telephone or other means of communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to perform Triage or Screening Services.

Triage or Screening: The evaluation of a Member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of the child's need for care.

Triage or Screening Waiting Time: The time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.

Tribal Federally Qualified Health Center: A Tribal Health Programs funded under the authority of Public Law 93-638 at 25 USC sections 5301 et seq. These Health Programs have elected to participate in Medi-Cal Tribal FQHCs and are subject to the payment terms of DHCS All Plan Letter (APL) 21-008. Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Service All-Inclusive Rate. The APM rate is updated annually and published in DHCS APL 21-008, Attachment #1. A list of Tribal FQHCs is published in DHCS APL 21-008, Attachment #2.

Tribal Health Program: A, American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Health Service under the Indian Self-Determination and Education Assistance Act and is defined in 25 USC section 1603(25).

Twenty-one (21) Day List: Long Term Care authorization requests must be submitted to CalOptima Health by contracted Long Term Care facilities within twenty-one (21) calendar days from start day of CalOptima Health coverage. The Onsite Visit Twenty-one (21) day list form may include:

1. Newly admitted Members;
2. Reauthorizations;
3. Bed holds; or
4. Deferrals.

Under Utilization: A condition wherein the optimal healthcare resources are not being delivered in the appropriate volume to provide quality health care services.

United States Department of Health and Human Services (U.S. DHHS): The federal agency that oversees Centers for Medicare and Medicaid Services (CMS) that works in partnership with state governments to administer the Medicaid program, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Unlawful Violence: Any assault, battery, or stalking.

Unsatisfactory Immigration Status (UIS) Member: A Member enrolled under the CalOptima Health Primary Contract with the Department of Health Care Services (DHCS), for whom, by virtue of their immigration status, federal financial participation is available only for emergency services and qualifying pregnancy-related services

as they are described in the CalOptima Health Primary Contract with DHCS, and are included in any of the following groups:

1. "Qualified" Non-Citizen (QNC), subject to, and have not met, the five-year bar;
2. Permanently Residing Under Color of Law (PRUCOL);
3. Senate Bill 75 (Chapter 18, Statutes of 2015), under the age of 19;
4. Young Adult Expansion (YAE), under the age of 26;
5. Trafficking and Crime Victim Assistance Program (TCVAP); and
6. Older Adult Expansion (OAE), 50 years of age or older.

Unsecured PHI/PII: Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.

Urban Indian Organization: A nonprofit corporate body situated in an urban center, governed by an urban American Indian controlled board of directors, as defined in 25 USC section 1603(29). UIOs participate in Medi-Cal as Tribal Federally Qualified Health Centers (Tribal FQHCs) or community clinics and are reimbursed via the Prospective Payment System or at fee-for-service rates.

Urgent Care: Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Urgent Care Service: Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

Urgent Request (pharmacy): A request for pharmaceutical services where application of the time frame for making routine or non-life-threatening care determinations:

1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or
2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Urgently Needed Services: Covered Services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, prolonged pain, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to his or her Health Network's service area.

Use: Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Use of PHI: Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Utilization Management (UM) Appeal: A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a services.

Utilization Management (UM) or Utilization Review: The evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

Utilization Management (UM) Program: A written document evaluated and revised on an annual basis that describes the Utilization Management policies, procedures, processes, and programs that are implemented organizationally to attain goals set forth by the health plan to meet health plan, state, federal, and accrediting agency requirements.

Utilization Management (UM) Standards: Conforming to an established rule that is approved and monitored for compliance by an authoritative agency or professional.

Utilization Management (UM) Work Plan: A written document, updated and revised annually, that evaluates the overall effectiveness of the Utilization Management Program.

Utilization Management (UM) Work Plan Evaluation: A written document, updated and revised annually, that evaluates the overall effectiveness of the Utilization Management (UM) Program.

Vaccines for Children (VFC): Program means the federally funded program that provides free vaccines for eligible Children aged eighteen (18) or younger (including all Medi-Cal eligible Children aged eighteen (18) or younger) and distributes immunization updates and related information to participating Providers.

Ventricular Assistive Device (VAD): A mechanical pump that is utilized to assist the heart to pump blood through the body.

Voluntary Inpatient Detoxification (VID): A fee-for-service (FFS) Medi-Cal benefit that is available to Medi-Cal beneficiaries who meet medical necessity criteria may receive Voluntary Inpatient Detoxification (VID) services in a general acute care hospital that is not a Chemical Dependency Treatment Facility or Institution for Mental Disease.

Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT): A survey administered both to individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons.

Waste: The overutilization or inappropriate utilization of services and misuse of resources.

Wellness and Prevention Programs: Programs that aim to prevent disease, disability, and other conditions; prolong life; promote physical and mental health and efficiency; and improve overall quality of life and well-being.

Wheelchair: A wheelchair may be a:

1. Manual wheelchair;
2. Power mobility device (PMD);
3. Power-assisted vehicle (POV); or
4. Push rim activated device.

Wheelchair Provider: A contracted provider, acting within his or her scope of practice, to furnish wheelchairs, SPCs, and related accessories to Members. The wheelchair provider ensures the wheelchair, SPCs, and accessories furnished are appropriate for the Member's medical and functional needs and may adjust or modify the furnished items as appropriate.

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.

Withhold Arrangement: Any payment mechanism approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with the requirements of 42 CFR section 438.6(b) under which a portion of a capitation rate is withheld from CalOptima Health, with a portion or all of the withheld amount to be paid to CalOptima Health for meeting targets specified under the DHCS contract for Medi-Cal.

Women, Infants, and Children (WIC): The special supplemental nutrition program for women, infants and children authorized by section 17 of the Child Nutrition Act of 1966, 42 U.S.C. 1786.

Workforce: Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for CalOptima Health is under the direct control of CalOptima Health, whether or not they are paid by CalOptima Health.

Workforce Member: Has the meaning in 45, Code of Federal Regulations Section 160.103 including: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

Working Capital Ratio: A liquidity ratio, calculated as current assets divided by current liabilities, that measures CalOptima Health's ability to pay its current liabilities with current assets. Working Capital Ratio is computed in accordance with Generally Accepted Accounting Principles (GAAP).

Working Days: Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays page.

Written Translation: The replacement of written text from one language into another.

"Your Rights" Attachment: A contractor's written notice sent to the Member that explains the Member's rights to challenge, free of charge, Contractor's action, and the Member's right to file an Appeal with Contractor, a Deemed Exhaustion, and the right to request a State Hearing or an Independent Medical Review (IMR).

Zip Code Match: The DHCS reported Member's home address zip code must match to a zip code within the Zip Code Range Table in order for that clinic or Health Network to be eligible for the Member assignment.

Zip Code Range: The Health Network Zip Code Range is established with all eligible Health Network PCP service address zip codes and any zip codes within a three (3) mile radius of the office zip code. The Clinic Zip Code Range is established with the clinic service address zip code and the zip codes having a three (3) mile radius from the clinic's zip code.

III. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	09/01/2004	DD.2000	Glossary of Terms	Medi-Cal
Revised	01/01/2008	AA.1000	Glossary of Terms	Medi-Cal
Revised	04/01/2011	AA.1000	Glossary of Terms	Medi-Cal

Action	Date	Policy	Policy Title	Program
Revised	09/01/2011	AA.1000	Glossary of Terms	Medi-Cal
Revised	11/01/2011	AA.1000	Glossary of Terms	Medi-Cal
Revised	12/01/2011	AA.1000	Glossary of Terms	Medi-Cal
Revised	01/01/2012	AA.1000	Glossary of Terms	Medi-Cal
Revised	03/01/2012	AA.1000	Glossary of Terms	Medi-Cal
Revised	06/01/2012	AA.1000	Glossary of Terms	Medi-Cal
Revised	12/01/2012	AA.1000	Glossary of Terms	Medi-Cal
Revised	01/01/2013	AA.1000	Glossary of Terms	Medi-Cal
Revised	02/01/2015	AA.1000	Glossary of Terms	Medi-Cal
Revised	03/01/2015	AA.1000	Glossary of Terms	Medi-Cal
Revised	04/01/2015	AA.1000	Glossary of Terms	Medi-Cal
Revised	05/01/2015	AA.1000	Glossary of Terms	Medi-Cal
Revised	06/01/2015	AA.1000	Glossary of Terms	Medi-Cal
Revised	07/01/2015	AA.1000	Glossary of Terms	Medi-Cal
Revised	08/01/2015	AA.1000	Glossary of Terms	Medi-Cal
Revised	09/01/2015	AA.1000	Glossary of Terms	Medi-Cal
Revised	04/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	05/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	06/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	07/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	08/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	09/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	10/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	11/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	12/01/2016	AA.1000	Glossary of Terms	Medi-Cal
Revised	01/01/2017	AA.1000	Glossary of Terms	Medi-Cal
Revised	06/01/2017	AA.1000	Glossary of Terms	Medi-Cal
Revised	07/01/2017	AA.1000	Glossary of Terms	Medi-Cal
Revised	12/01/2017	AA.1000	Glossary of Terms	Medi-Cal
Revised	01/01/2020	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	03/01/2021	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	10/01/2021	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	11/01/2022	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	10/01/2023	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	12/01/2023	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	12/01/2023	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	02/01/2024	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal

Action	Date	Policy	Policy Title	Program
Revised	03/01/2024	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	05/01/2024	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	02/01/2025	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal
Revised	09/01/2025	AA.1000	Medi-Cal Glossary of Terms	Medi-Cal