Policy:	FF.4000
Title:	**Whole-Child Model – Financial Reimbursement for Capitated Health Networks**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/ Michael Hunn 06/20/2024*
Effective Date:	07/01/2019
Revised Date:	06/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the reimbursement process for CalOptima Health to distribute Whole-Child Model (WCM) payments timely and accurately to Health Networks, including Health Maintenance Organizations (HMO), Physician Hospital Consortia (PHC), and Shared Risk Groups (SRG).

II. POLICY

A. CalOptima Health shall pay the Health Network in accordance with the Health Network's Contract for Health Care Services, the CalOptima Health Board of Directors (BOD)-approved payment methodology, and the terms and conditions of this Policy.

1. CalOptima Health shall pay the Health Network, except Kaiser Foundation Health Plan, Inc. (Kaiser), in accordance with this Policy for dates of service on or before June 30, 2023.

2. CalOptima Health shall pay Kaiser in accordance with this Policy for dates of service on or before December 31, 2023.

B. CalOptima Health's WCM reimbursement methodology for Health Networks is based on the number of California Children's Services (CCS) Program-eligible Members, as identified by the local CCS Program, enrolled in Health Networks during the applicable period.

C. If the local CCS Program identifies that an individual was not eligible for the CCS Program and retroactively terminates CCS eligibility, CalOptima Health shall recover payments made to the Health Network for such individual.

D. CalOptima Health Direct-Administrative (COD-A) is financially responsible for all Covered Services provided during a month in which a CCS-eligible Member has retroactive eligibility.

E. In accordance with CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage, CalOptima Health shall exclude Members from the provision of reinsurance as of the effective date of the Member being CCS-eligible.

F. The Measurement Period for WCM payments is established by fiscal year (FY), July 1 to June 30. In accordance with Section II.J.3 of this Policy, CalOptima Health shall keep each Measurement Period (FY1) open for thirty (30) months after the end of each Measurement Period before the risk corridor reconciliation is considered finalized (e.g., Measurement Period FY 2019-20 (July 1, 2019 – June 30, 2020) will be finalized based on claims paid through December 31, 2022).

G. CalOptima Health reimburses Health Networks, with the exception of Kaiser, for services on or before June 30, 2023, rendered to enrolled CCS-eligible Members based on a methodology that includes the following components described in this Policy:

1. Initial Capitation Payments;

2. Interim catastrophic payment; and

3. Retrospective risk corridor settlements.

H. CalOptima Health shall reimburse Kaiser for services on or before December 31, 2023, rendered to enrolled CCS-eligible Members based on a methodology described in Section III.G. of this Policy.

I. CalOptima Health may adjust Health Network initial Capitation Payment rates subject to Department of Health Care Services (DHCS) funding updates for the Measurement Period.

J. The WCM payment timelines are:

1. Initial Capitation Payment: CalOptima Health shall pay monthly on or before the fifteenth (15th) calendar day of the month.

2. Interim catastrophic payment: CalOptima Health shall pay quarterly based on the refreshed data for each Measurement Period as follows:

CCS Eligible and Claims Incurred for Dates of Service	Claims Payment Period	Interim Catastrophic Calculation (Payment/ Recoupment) Date
July 1 – September 30, FY1	FY1 paid through September 30, FY1	No later than November 30, FY1
July 1 – December 31, FY1	FY1 paid through December 31, FY1	No later than February 28, FY1
July 1 – March 31, FY1	FY1 paid through March 31, FY1	No later than May 31, FY1
July 1 – June 30, FY1	FY1 paid through June 30, FY1	No later than August 31, FY2
July 1 – June 30, FY1	FY1 paid through September 30, FY2	No later than November 30, FY2

3. Retrospective risk corridor settlement: CalOptima Health shall pay annually based on the refreshed data for each Measurement Period as follows:

Measurement Period (CCS Eligible and Claims Incurred for Dates of Service for FY1)	Claims Payment Period	Risk Corridor Settlement (Payment/ Recoupment) Date
July 1 – June 30, FY1	Measurement Period plus 6 months: FY1 paid through December 31, FY2	No later than May 15, FY2
July 1 – June 30, FY1	Measurement Period plus 18 months: FY1 paid through December 31, FY3	No later than May 15, FY3
July 1 – June 30, FY1	Measurement Period plus 30 months (final): FY1 paid through December 31, FY4	No later than May 15, FY4

III. PROCEDURE

A. Initial Capitation Payment

1. CalOptima Health shall provide monthly Capitation Payments for CCS-eligible Members enrolled in the Health Networks at Capitation Rates per Member per month (PMPM) developed by CalOptima Health, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services.

2. CalOptima Health shall process the initial Capitation Payment in accordance with CalOptima Health Policy FF.1001: Capitation Payments. CalOptima Health shall issue one (1) payment that includes the initial Capitation Payment for CCS-eligible Members combined with the Capitation Payment for non-CCS eligible Members.

B. Interim Catastrophic Payment

1. Health Networks shall submit paid claims through the existing monthly External Decision Data submission for covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members monthly, by the fifteenth (15th) calendar day after the month ends for all Open Measurement Periods. Health Networks shall submit claims using CalOptima Health's proprietary format and file naming convention.

    a. An HMO, with the exception of Kaiser, shall submit claims for covered hospital and covered physician expenses;

    b. The Primary Physician Group of a PHC shall submit claims for covered physician expenses;

    c. The Primary Hospital of a PHC shall submit claims for covered hospital expenses; and

    d. An SRG shall submit claims for covered physician expenses.

2. CalOptima Health shall validate and reprice the submitted claims based on the CalOptima Health contracted and non-contracted rates following the lesser of the amount paid for covered physician and hospital expenses. Repricing will be made at one hundred percent (100%) of the amount paid if Medi-Cal has no value for the five (5)-digit numerical Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, or other code as assigned by DHCS. Should a value be assigned following the repricing of these claims prior to the final settlement of any given measurement period, CalOptima Health will utilize that value for the

five (5)-digit numerical CPT code, HCPCS code, or other code as assigned by DHCS in the Retrospective Risk Corridor discussed in Section III.C. These allowable claims, as determined by CalOptima Health, shall represent the repriced WCM medical expenses used in the reconciliation process for the interim catastrophic reimbursement. Claims paid by the Health Network at a higher rate than would be payable by CalOptima Health, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima Health would have paid under similar circumstances, not to exceed actual payments made.

3. Upon request, an eligible Health Network shall provide, within five (5) business days, detailed support for any individual claim for which billed charges are greater than or equal to ten thousand dollars ($10,000), including copies of the claim form, cancelled check, explanation of benefits (EOB), Remittance Advice Detail (RAD), and other information as requested by CalOptima Health. All non-contracted emergency hospital inpatient claims require submission of the authorization distinguishing days considered emergency and post-stabilization.

4. CalOptima Health shall notify an eligible Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima Health may reject a file for missing information or incorrect data. If CalOptima Health rejects a file, an eligible Health Network shall resubmit a corrected file no later than September 30, FY2 of the claims payment period pursuant to Section II.J.2 of this Policy. Any timely resubmission after the fifteenth (15th) of the month will be included in the subsequent month's process. A paid claims file initially submitted or a corrected file resubmitted by an eligible Health Network after the September 30, FY2 deadline will be processed in accordance with the requirements of the annual retrospective risk corridor reconciliation as set forth in Sections II.J.3 and III.C of this Policy.

5. For a complete claims paid file accepted by CalOptima Health, CalOptima Health shall notify an eligible Health Network of the results as follows:

    a. If CalOptima Health receives the file by the fifteenth (15^{th}) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of that month.

    b. If CalOptima Health receives the file after the fifteenth (15^{th}) of the month, notice of the results will be provided no later than thirty (30) business days after the fifteenth (15th) of the subsequent month.

6. An eligible Health Network may appeal claim denials and payments within sixty (60) business days after the date of CalOptima Health's quarterly interim catastrophic payment remittance advice.

    a. The eligible Health Network shall submit a request for appeal, in writing, to CalOptima Health at:

    WCMReimb@caloptima.org

    Or by U.S. mail to:

    Attn: Coding Initiatives Department - WCM Claims
    CalOptima Health
    505 City Parkway West
    Orange CA 92868

b. An appeal claims submission file shall only include specific claims to be reconsidered.

c. The eligible Health Network shall provide detailed claims support for each claim, including copies of the claim form, cancelled check, EOB, RAD, or any other information, as requested by CalOptima Health.

d. CalOptima Health shall notify the eligible Health Network of file acceptance or rejection within three (3) business days after receipt of the appeal file.

i. CalOptima Health may reject a file for any missing information or incorrect data.

ii. If CalOptima Health rejects a file, the eligible Health Network shall resubmit a corrected file within five (5) business days after receipt of notification from CalOptima Health.

e. CalOptima Health shall process an appeal and provide an eligible Health Network with the detailed report and payment, if applicable, on the following quarterly reimbursement period or within forty-five (45) business days after receipt of the appeal, whichever is later.

7. For each CCS-eligible Member in a given Measurement Period, CalOptima Health shall reimburse at one hundred percent (100%) of the repriced amount for the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members in excess of the thresholds which are:

a. $17,000 for covered physician expenses; and

b. $150,000 for covered hospital expenses.

8. CalOptima Health shall reconcile covered physician and covered hospital expenses separately.

9. CalOptima Health shall issue interim catastrophic payments to Health Networks in accordance with the timelines in Section II.J.2 of this Policy.

10. In the event of an extraordinary case(s) or significant cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

a. Within forty-five (45) business days after receipt of the Health Network's request, CalOptima Health Claims Department will review the request and documentation and forward the recommendation to approve or deny the request to CalOptima Health Chief Executive Officer (CEO) and Chief Financial Officer (CFO).

b. The CEO and CFO will make a final determination. CalOptima Health Finance Department will provide written notification of the final determination to the Health Network no later than sixty (60) business days after receipt of the Health Network's request. If and to the extent approved by CalOptima Health, the expedited cash funding will be included and reconciled in the next quarterly interim catastrophic payment or annual risk corridor calculation.

C. Retrospective Risk Corridor

1. After the December claims submission, CalOptima Health shall perform an annual retrospective risk corridor reconciliation for all Open Measurement Periods.

2. CalOptima Health shall validate and reprice the submitted claims, as described in Sections III.B.1 and III.B.2. of this Policy, based on the lesser of the CalOptima Health contracted and non-contracted rates or the amount actually paid for covered physician and hospital expenses. Repricing will be made at one hundred percent (100%) of the amount paid if Medi-Cal has no value for the five-digit numerical CPT code, HCPCS code, or other code as assigned by the DHCS within the retrospective risk corridor period. These allowable claims, as determined by CalOptima Health, shall represent the covered hospital and covered physician expenses rendered to enrolled CCS-eligible Members used in the retrospective risk corridor reconciliation. Similar to the interim catastrophic reimbursement, claims paid by the Health Network at a higher rate than would be payable by CalOptima Health, based on the above methodology, may be subject to additional review for potential adjustment of the payment methodology to represent what CalOptima Health would have paid under similar circumstances, not to exceed actual payments made.

3. CalOptima Health shall perform the retrospective risk corridor reconciliation for physician capitation and hospital capitation separately.

    a. The baseline for the retrospective risk corridor reconciliation is an amount equal to the total Capitation Rate PMPM less the administrative and medical management loads PMPM developed by CalOptima Health, approved by the BOD, and set forth in the Health Network's Contract for Health Care Services, multiplied by the number of CCS-eligible Members enrolled in the Health Networks during the applicable Measurement Period.

    b. The net difference between the baseline and the qualified WCM medical expenses from Section III.C.2 of this Policy shall be applied to the risk corridor ranges approved by the BOD to determine an amount to be added or subtracted in the retrospective risk corridor reconciliation and referred to as risk corridor result in this Policy.

Threshold	CalOptima Health's Risk/Surplus Share
> 115%	95%
115%	90%
105%	75%
102%	50%
100%	0%
98%	50%
95%	75%
85%	90%
< 85%	100%

    c. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A. and III.B. of this Policy respectively for the applicable Measurement Period results in a positive amount, the retrospective risk corridor reconciliation computes the risk corridor payment.

    d. If a total of baseline and risk corridor result subtracting initial Capitation Payments (less the administrative and medical management loads) and interim catastrophic reimbursement from Sections III.A and III.B of this Policy respectively for the applicable Measurement Period results in a negative amount, the retrospective risk corridor reconciliation computes the risk

corridor recoupment, which will be deducted from future initial Capitation Payments pursuant to Section III.C. of this Policy.

e. Administrative and medical management components of CCS reimbursement will be based on total reimbursement at the established percentage, inclusive of all reimbursement attributed to the Measurement Period regardless of when paid, including the initial Capitation Payment, interim catastrophic reimbursement, and retrospective risk corridor settlements. The established percentage shall be the administrative rate established by DHCS for the WCM program for the rate period, subject to a final reconciliation process once DHCS issues final rates for the rate period.

4. No later than March 31, CalOptima Health shall provide the retrospective risk corridor reconciliation to the Health Networks. If, upon review of the retrospective risk corridor reconciliation, the Health Networks object to the calculations or medical expenses determination, the Health Networks may follow the dispute process outlined in Section III.B.6. of this Policy within thirty (30) calendar days from the issuance of the retrospective risk corridor reconciliation.

5. If CalOptima Health does not receive any written objection from the Health Networks, CalOptima Health shall pay the risk corridor payment within fifteen (15) calendar days after the expiration of the review period or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the expiration of the review period.

6. If CalOptima Health receives written objection from the Health Networks within the objection period, CalOptima Health shall review and provide responses to the Health Networks within forty-five (45) calendar days after the date of receipt of the written objection.

7. CalOptima Health shall pay the risk corridor payment within fifteen (15) calendar days after the date of issuance of the final retrospective risk corridor reconciliation or deduct the risk corridor recoupment from the initial Capitation Payment of a month following the issuance of the final retrospective risk corridor reconciliation.

8. In the event of significant interim cash deficiencies, a Health Network may submit a formal written request, along with supporting documentation, for an expedited cash funding payment.

   a. Within the time limit specified in Section III.B.10.a. of this Policy, CalOptima Health Claims Administration Department will review the request and documentation and forward the recommendation to approve or deny the request to the CEO and CFO.

   b. The CEO and CFO will make a final determination. CalOptima Health will notify the Health Network of the final determination in accordance with Section III.B.10.b. of this Policy. If and to the extent approved by CalOptima Health, the expedited cash funding will be included and reconciled in the next annual risk corridor calculation.

D. Medical expenses used in the reconciliation process for interim catastrophic reimbursement and retrospective risk corridor settlement shall be consistent with the financial risk in accordance with the Division of Financial Responsibility (DOFR) of the Health Network's Contract for Health Care Services.

E. In the event of an extraordinary case(s), where a claim is paid at rates greater than the CalOptima Health contracted or non-contracted rates, a Health Network may submit a formal written request for additional review. CalOptima Health will conduct further evaluation of such cases and determine whether any repricing adjustments are warranted and appropriate. Any approved repricing

adjustments will be included in the next interim catastrophic payment or annual retrospective risk corridor reconciliation, whichever occurs first.

F. In the event that a Health Network is dissatisfied with the results of the interim catastrophic payment or annual retrospective risk corridor reconciliation after utilizing the dispute process set forth in this Policy, then the Health Network shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Health Policy HH.1101 CalOptima Health Provider Complaint.

G. Kaiser Reimbursement Process

1. CalOptima Health shall provide a monthly administrative capitation payment to Kaiser for enrolled CCS-eligible Members following the regular Medi-Cal capitation process and timeline.

2. Effective upon the implementation of Medi-Cal Rx, no sooner than April 1, 2021, pharmacy expenses for services rendered to enrolled CCS-eligible Kaiser Members, including Hepatitis C drug therapy, shall be excluded from this Policy and shall not be subject to reimbursement as described in Sections III.G.3 through III.G.5 of this Policy.

3. Kaiser shall submit a monthly report for covered hospital, physician, ancillary, facility, and pharmacy expenses for services rendered to enrolled CCS-eligible Members in a format as agreed by CalOptima Health and Kaiser. Kaiser shall submit a report using CalOptima Health's proprietary format and file naming convention, or the equivalent, as agreed by CalOptima Health and Kaiser.

   a. Reimbursement for Kaiser Hepatitis C drug therapy and Behavioral Health Therapy (BHT) claims for services provided to CCS-eligible Members shall be at the same supplemental rates at which such services are reimbursed for all other Kaiser Members, under a separate process. Therefore, all Hepatitis C drug therapy and BHT claims will be excluded from the monthly reconciliation described in Section III.G.5.

4. CalOptima Health shall validate and reprice the submitted claims based on:

   a. Internal Kaiser pharmacy claims shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima Health contracted Pharmacy Network rate;

   b. Physician, Hospital and Ancillary Kaiser system claims (services provided by those providers operating through the Kaiser System as defined in Kaiser's Contract for Health Care Services with CalOptima Health), shall be reimbursed at the equivalent of one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule. CalOptima Health updates the CalOptima Health Medi-Cal Fee Schedule in accordance with CalOptima Health Policy FF.1002: CalOptima Health Medi-Cal Fee Schedule. Reimbursement will be based on the CalOptima Health Medi-Cal Fee Schedule in effect on the date of service;

   c. Professional services provided by Kaiser system CCS-paneled providers shall be reimbursed at one hundred forty percent (140%) of the CalOptima Health Medi-Cal Fee Schedule; and

   d. For non-Kaiser system pharmacy and other services, CalOptima Health shall reprice the claims at the rate paid by Kaiser under its contract with the provider, or the rate negotiated and paid by Kaiser. Kaiser may elect to enter into a contract with CalOptima Health providers that have reciprocity requirements, in which case, CalOptima Health will reprice the claim at the contracted reciprocal rate.

5. Repricing Results and Reconciliation

    a. CalOptima Health shall notify Kaiser of the results within thirty (30) business days after the date of CalOptima Health's receipt of the complete claims paid file.

    b. Kaiser shall provide a rebuttal to, or acceptance of, the results within thirty (30) business days after the date of receipt of the results.

    c. CalOptima Health, with the cooperation of Kaiser, shall perform a reconciliation of paid covered service expenses, if necessary.

    d. CalOptima Health shall issue payment to Kaiser within fifteen (15) business days after receipt of the repricing acceptance or the completion of the reconciliation.

    e. In the event that Kaiser is still dissatisfied with the repricing after rebuttal, reconciliation, and payment, then Kaiser shall be entitled to pursue the matter through the provider complaint process in accordance with CalOptima Health Policy HH.1101 CalOptima Health Provider Complaint.

H. If a Health Network identifies an Overpayment of WCM payments, a Health Network shall return the Overpayment within sixty (60) calendar days after the date on which the Overpayment was identified, and shall notify CalOptima Health's Accounting Department, in writing, of the reason for the Overpayment.

    1. CalOptima Health shall notify a Health Network of acceptance, adjustment, or rejection of the Overpayment no later than three (3) business days after receipt.

    2. CalOptima Health shall coordinate with a Health Network on the process to return the Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Policy FF.1001: Capitation Payments
D. CalOptima Health Policy FF.1002: CalOptima Health Medi-Cal Fee Schedule
E. CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage
F. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
G. Department of Health Care Services All Plan Letter (APL) 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers (Supersedes APL 17-003)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/04/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
08/02/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2019	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	12/03/2020	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	03/04/2021	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	09/01/2022	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	07/01/2023	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal
Revised	06/01/2024	FF.4000	Whole-Child Model – Financial Reimbursement for Capitated Health Networks	Medi-Cal

IX. GLOSSARY

Term	Definition
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.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Direct-Administrative (COHD-A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members as described in CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct
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.
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.
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 is binding on a Physician Hospital Consortium (PHC) a physician group under a shared risk contract, or an HMO.
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.

Term	Definition
	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 health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

Term	Definition
	16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and 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.
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
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, and Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members enrolled to that Health Network.
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.
Measurement Period	The Fiscal Year spanning July 1 to June 30. Each Measurement Period will remain open until the third annual report is issued to the Health 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.
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.
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).
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for enrolled Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.