Policy:	GG.1667
Title:	**CalAIM Population Health Management Program**
Department:	Equity and Community Health
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 08/22/2024*
Effective Date:	06/01/2023
Revised Date:	07/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines CalOptima Health's Population Health Management (PHM) Program and describes the process by which CalOptima Health, Health Networks, and Providers engage Members across delivery systems and carved-out services.

II. POLICY

A. CalOptima Health shall establish and maintain a PHM Program in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program.

B. The PHM Program ensures that all Members have access to a comprehensive set of services based on their individual needs and preferences across the continuum of care, which promotes improved outcomes, and Health Equity.

C. The PHM Program shall align with the National Committee for Quality Assurance (NCQA) Health Plan and Health Equity standards.

D. The PHM Program includes Basic Population Health Management (BPHM), Care Management, Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services (TCS).

E. The PHM Program will include four (4) domains that define the PHM Framework:

1. PHM Strategy and Population Needs Assessment (PNA);

2. Gathering Member Information;

3. Understanding Risk; and

4. Providing Services and Supports.

F. CalOptima Health will meet the requirements of the PHM Framework domains in accordance with Section III of this Policy.

G. The goals of the PHM Program are to:

1. Build trust and meaningfully engagement with Members;

2. Provide interventions to support health and wellness for all Members;

3. Utilize data-driven Risk Stratification, standardize assessment processes and predictive analytics to address gaps in care;

4. Provide Care Management services for Members with increased risk of poor health outcomes;

5. Robust TCS;

6. Identify and mitigate Social Drivers of Health (SDOH) to reduce disparities; and

7. Address upstream factors by linking Members to public health and social services.

H. DHCS will provide a PHM Service, a single, statewide, open-source Risk Stratification and Segmentation (RSS) methodology, to support key PHM Program functions which include but not limited to:

1. Data integration;

2. Risk Stratification Segmentation (RSS) tiering;

3. Screening and assessment;

4. Analytics and reporting; and

5. User access to data.

III. PROCEDURE

A. PHM Strategy

1. The PHM Strategy is a comprehensive, accountable plan of action for addressing Member needs and preferences.

2. CalOptima Health shall develop an annual PHM Strategy that:

a. Outlines the PHM Program;

b. Prioritizes strong ties to the community;

c. Incorporates cross-sector strategies to improve health in all neighborhoods and communities where Members reside, especially those with poor health outcomes;

d. Incorporates strategies and interventions to address findings from the PNA and the Orange County Health Care Agency's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP); and

e. Include strategies for improving access to children's preventive health visits and developmental screenings, ensuring follow up and Care Coordination needs identified from screenings delivered.

3. PHM Strategy shall align with the DHCS Comprehensive Quality Strategy (CQS) Clinical Focus Areas and Bold Goals.

   a. Clinical Focus Areas – DHCS defines three (3) focus areas:

      i. Children's preventive care;

      ii. Maternity care and birth equity; and

      iii. Behavioral health integration.

   b. Bold Goals – DHCS has defined and identified the following bold goals for year 2025:

      i. Close racial/ethnic disparities in well-child visits and immunizations;

      ii. Close maternity care disparity for Black and Native American persons by fifty percent (50%);

      iii. Improve maternal and adolescent depression screening by fifty percent (50%);

      iv. Improve follow up for mental health and substance use disorder by fifty percent (50%); and

      v. Ensure all health plans exceed the fiftieth (50^{th}) percentile for all children's preventive care measures.

4. Annually CalOptima Heath shall review, update, and submit the PHM Strategy to DHCS.

5. The CalOptima Health Population Health Management Committee (PHMC) shall provide oversight and monitor the PHM Strategy on a quarterly basis, and report to the Quality Improvement and Health Equity Committee (QIHEC).

B. Population Needs Assessment (PNA)

1. CalOptima Health shall conduct a PNA in accordance with regulatory entities, strategic priorities, CalOptima Health Board of Directors directives, and any other managed care program requirements, to gather and evaluate population-level data related to the health and Social Needs of Members, including:

   a. Cultural and linguistic needs;

   b. Health education needs;

   c. Health disparities and inequities;

   d. Root causes of barriers related to coverage, access, quality, health outcomes; and

   e. SDOH needs.

2. The PNA must address the special needs of CalOptima Health populations, including:

    a. Seniors and Persons with Disabilities (SPD);

    b. Children and adolescents;

    c. Persons with disabilities;

    d. Members with Serious and Persistent Mental Illness (SPMI);

    e. Members with Limited English Proficiency (LEP); and

    f. Other Member subgroups from diverse cultural, racial, and ethnic backgrounds in the PNA findings.

3. CalOptima Health will satisfy the following PNA requirements:

    a. CalOptima Health will use reliable data sources to identify Member health needs and health disparities. This process will include analyzing data to identify the differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to Members. Data sources will include:

        i. The most recently available Consumer Assessment of Healthcare Providers and Systems (CAHPS);

        ii. CalOptima Health-specific health disparities data identified via claims, encounters, and other sources of aggregate Member data;

        iii. Orange County Health Care Agency and data collected through the CHA/CHIP process;

        iv. Relevant data from Subcontractors and Downstream Subcontractors;

        v. Healthcare Effectiveness Data and Information Set (HEDIS®);

        vi. Managed Care Accountability Sets (MCAS); and

        vii. Language assistance services utilization reports.

    b. Based on PNA findings, CalOptima Health will review and update health education, cultural and linguistic services, and quality improvement activities.

    c. CalOptima Health shall include stakeholders, not limited to the Member Advisory Committee (MAC) in PNA activities and in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

    d. CalOptima Health shall engage the Provider Advisory Committee (PAC) in the PNA through the following process:

        i. Provide the PAC an opportunity to provide comments on the PNA;

        ii. Report PNA findings to the PAC;

        iii. Discuss improvement opportunities; and

iv. Update the PAC on progress made to PNA goals.

e. Utilizing the PNA findings, feedback from its governing committee and regulatory guidance, CalOptima Health shall develop equity-focused interventions and build community partnerships to address the underlying factors of identified health disparities, including SDOH.

4. PNA monitoring and reporting shall be done as follows:

   a. On an annual basis, CalOptima Health will evaluate and update the PNA. CalOptima Health will submit the PNA report to regulatory and/or accreditation entities as required.

   b. On an annual basis, the Equity and Community Health Department shall submit the PNA report to the PHMC who will report key findings to the CalOptima Health QIHEC for the evaluation and monitoring of population health services, in accordance with CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC).

   c. CalOptima Health or a Health Network shall provide information regarding PNA findings and workplan to its governing committees, boards as appropriate, and Providers to support the appropriate delivery of health education, in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 23-021: Population Needs Assessment and Population Health Management Strategy and CalOptima Health Policy EE.1103: Provider Network Training.

5. Local Health Department Collaboration (LHDs)

   a. CalOptima Health, as required by DHCS, will meaningfully participate in Orange County Health Care Agency's CHA/CHIP process.

   b. Meaningful participation may include, but is not limited to funding, staffing, data exchange, other relevant functions

6. Health Equity Promotion

   a. CalOptima Health will incorporate the CHA/CHIP in PNA findings, build community partnerships, and improve Member participation to fully understand the barriers preventing all populations from receiving care and preventive services as well as SDOH.

C. Gathering Member Information

1. CalOptima Health will use an RSS methodology to identify each Member's health and Social Needs, as well as their health goals and preferences.

2. CalOptima Health will leverage a broad set of data sources in the RSS methodology which includes, but is not limited to:

   a. Managed care and fee for service medical and dental claims and encounters;

   b. Screenings and assessments;

   c. Race, ethnic, and language information;

d. Disability status;

e. Admissions, discharge and transfer (ADT) data;

f. Referrals and authorizations;

g. Behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment, and other Substance Use Disorders (SUD) and other non-specialty mental health services information;

h. County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information;

i. Pharmacy claims, encounters;

j. Laboratory results;

k. Housing status utilizing International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) Z-code;

l. For Members under twenty-one (21), developmental and Adverse Childhood Experiences (ACEs) screenings; and

m. Additional data from the DHCS PHM Service which includes but not limited to:

   i. Social services reports;

   ii. Electronic Health Records (EHR);

   iii. Disengaged Member reports;

   iv. Justice involved data; and

   v. Homelessness Management Information System (HMIS).

3. Initial Screening Process

   a. CalOptima Health will screen newly enrolled Members by providing Health Information Form Member Evaluation Tool (HIF/MET), in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

   b. CalOptima Health shall review HIF/MET responses and provide additional outreach, Case Management, and Care Coordination activities, in accordance with CalOptima Health Policies GG.1301: Comprehensive Case Management Process and GG.1201: Health Education Programs.

   c. Member shall receive an Initial Health Appointment (IHA), in accordance with CalOptima Health Policy GG.1613: Initial Health Appointment.

   d. Children and youth will be provided with initial screenings, in accordance with CalOptima Health Policy GG.1116: Pediatric Prevention Services.

D. Understanding Risk

1. CalOptima Health will utilize the following to understand a Member's risk:

   a. RSS; and

   b. Assessments and reassessments.

2. Risk Segmentation and Stratification (RSS)

   a. Prior to the launch of the DHCS PHM Service, CalOptima Health will use an RSS approach that aligns with regulatory and accreditation standards as follows:

      i. Includes integration of data sources, findings from the PNA, clinical, behavioral, population, and Social Needs data, and a broad range of internal and external data;

      ii. Avoids and reduces biases to prevent exacerbation of health disparities by continuously evaluating key performance indicators and RSS outputs and monitoring health disparities over time;

      iii. Stratifies Members during each of the following time frames:

         a) Upon each Member's enrollment;

         b) At least annually after each Member's enrollment;

         c) Upon a significant change in health status or level of care of the Member; and

         d) Upon receipt of new information, CalOptima Health determines as potentially changing a Member's level of risk and need.

      iv. Places Members into risk tiers to identify those that should be connected to available interventions and services; and

      v. CalOptima Health's RSS methodology will be continuously evaluated for effectiveness.

   b. Following the launch and availability of the DHCS PHM Service, CalOptima Health will:

      i. Integrate and use the DHCS system to conduct RSS, screening and assessment, BPHM, and Member engagement and health education activities, in accordance with federal and state privacy rules and regulations.

      ii. CalOptima Health may also continue to use more real-time data from local sources to connect Members to services and resources, as needed.

3. Assessment and Reassessment

   a. CalOptima Health, its Health Networks, and Providers will ensure assessment of the following Members:

      i. Members entering Complex Case Management, in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management Process.

ii. Members entering Enhanced Care Management, in accordance with CalOptima Health Policies GG.1353: CalAIM Enhanced Care Management Services Delivery, GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach, and GG.1356: CalAIM Enhanced Care Management Administration.

iii. Pregnant individuals in accordance with CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services Program.

iv. Seniors and persons with disabilities who meet the definition of "high risk" as described in CalOptima Health Policies GG.1323: Seniors and Persons with Disabilities and Health Risk Assessments, and GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management.

b. CalOptima Health, its Health Networks, and Providers will ensure assessment and reassessment of the following Members:

i. Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver)

a) CalOptima Health will continue to assess Members who need LTSS using the existing standardized LTSS referral questions at least every twelve (12) months.

ii. Children with Special Health Care Needs (CSHCN).

E. Providing Services and Supports

1. CalOptima Health's PHM program ensures Member support and services according to Member's risk, assessment and reassessment needs through the following:

a. Basic Population Health Management (BPHM);

b. Care Management Programs;

c. Enhanced Care Management (ECM); and

d. Transitional Care Services (TCS).

2. Basic Population Health Management (BPHM)

a. BPHM is a collaborative process that ensures all Members have access to:

i. Primary Care services in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition Role, and Responsibilities:

a) BPHM will identify Members who are not using Primary Care through utilization and enrollment data stratified by race, ethnicity, and language for outreach to ensure Member engagement with Members assigned PCPs.

ii. Coordination of care and Referrals for medical, carved out, linked, and Community Supports.

iii. Community Health Workers, in accordance with CalOptima Health PHM Strategy and CalOptima Health Policy GG.1213: Community Health Workers.

iv. Wellness and prevention programs in accordance with CalOptima Health Policy GG.1201: Health Education Programs.

v. Self-management tools in accordance with CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools, and provide at a minimum information on the following areas:

    a) Healthy weight (BMI) maintenance;

    b) Smoking and tobacco use cessation;

    c) Encouraging physical activity;

    d) Healthy eating;

    e) Managing stress;

    f) Avoiding at-risk drinking; and

    g) Identifying depressive symptoms.

vi. Disease Management programs in alignment with regulatory requirements at a minimum.

    a) These programs will incorporate health education interventions, identify Members for engagement and seek to close care gaps with a focus on improving equity and reducing health disparities.

    b) The Disease Management programs will address at a minimum the following conditions:

        i) Diabetes;

        ii) Cardiovascular disease;

        iii) Asthma; and

        iv) Depression.

vii. Programs to address maternal health outcomes including access to prenatal and postpartum care, in accordance with CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services Program.

viii. CalOptima Health will develop strategies to address different utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring.

ix. PHM for children that ensure all children under twenty-one (21) years of age with full scope Medi-Cal status will receive appropriate preventive, mental health, developmental and specialty EPSDT in accordance with CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

b. CalOptima Health's BPHM services will promote Health Equity and align with National Standards for Culturally and Linguistically Appropriate Services (CLAS).

c. BPHM will be provided to Members enrolled in ECM by the ECM Provider.

3. Care Management Programs

a. Complex Care Management (CCM)

i. CalOptima Health CCM services are provided to Members as mandated by federal and state regulations, and in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management Process.

ii. Member eligibility is determined by CalOptima Health's RSS process and in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management Process.

iii. CCM is provided to Members under the age of twenty-one (21) in accordance with CalOptima Health Policies GG.1330: Case Management - California Children's Services Program/Whole-Child Model, and GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

b. Enhanced Care Management (ECM)

i. CalOptima Health ECM services address the clinical and nonclinical needs of the highest-need Members through intensive coordination of health and health-related services, in accordance with CalOptima Health Policies GG.1353: CalAIM Enhanced Care Management Services Delivery, GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach, and GG.1356: CalAIM Enhanced Care Management Administration.

ii. Members cannot be enrolled in ECM and CCM at the same time.

c. Transitional Care Services (TCS)

i. CalOptima Health and Health Networks will provide TCS for Members transferring from one setting or level of care to another, in accordance with CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS) .

F. Coordination of Services and Resources for Members

1. CalOptima Health will coordinate services and connect Members to resources with Third Party Entities in accordance with CalOptima Health Policy EE.1144: Memorandum of Understanding (MOU) Requirements for CalOptima Health and Third-Party Entities.

2. By January 1, 2025, CalOptima Health will establish relationships and processes to conduct closed loop referrals.

i. These processes will coordinate and refer Members to at least the following community resources and follow up to ensure services were rendered:

a) ECM;

b) Community Supports;

c) Services provided by CHWs, peer counselors, and local community organizations;

d) Dental Providers;

e) California Children's Services (CCS);

f) Developmental Services (DD);

g) CalFresh;

h) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Providers;

i) County social service agencies and waiver agencies for IHSS and other home and community-based services (HCBS);

j) Specialty mental health services to ensure Members receive timely mental health services (in the Health Network, county Mental Health Plan (MHP) network, or Medi-Cal FFS delivery system) without delay regardless of where they initially seek care, in accordance with DHCS APL 22-005: No Wrong Door For Mental Health Services Policy; and

k) The appropriate delivery system for SUD services (in DMC or DMC-ODS).

b. By January 1, 2025, CalOptima Health will coordinate warm handoffs with local health agencies and other public benefits programs including, but not limited to:

i. Orange County Health Care Agency

ii. CalFresh

iii. CalWORKs

iv. Early Start

v. Supplemental Security Income.

G. Key Performance Indicators (KPIs)

1. CalOptima Health will assess the implementation, operations, and effectiveness of the PHM Program to understand the impact on outcomes and Health Equity over time.

2. CalOptima Health will develop KPIs in alignment with the DHCS PHM Program Guide requirements to continuously monitor and report on the PHM Program performance.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Comprehensive Wellness Program for Members under Twenty-One
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Policy EE.1103: Provider Network Training
D. CalOptima Health Policy EE.1144: Memorandum of Understanding (MOU) Requirements for CalOptima Health and Third-Party Entities
E. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
F. CalOptima Health Policy GG.1116: Pediatric Prevention Services
G. CalOptima Health Policy GG.1121: Early and Periodic Screening. Diagnosis and Treatment (EPSDT) Services
H. CalOptima Health Policy GG.1130: Community Based Adult Services (CBAS) Eligibility, Authorization, Availability, and Care Coordination Processes
I. CalOptima Health Policy GG.1201: Health Education Programs
J. CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools
K. CalOptima Health Policy GG.1213: Community Health Worker Services
L. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
M. CalOptima Health Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
N. CalOptima Health Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management
O. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
P. CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
Q. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Services Delivery
R. CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach
S. CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration
T. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS)
U. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
V. CalOptima Health Policy GG.1613: Initial Health Appointment
W. CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC)
X. CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program
Y. CalOptima Health Policy GG.1800: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
Z. CalOptima Health Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric
AA. CalOptima Health Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
BB. CalOptima Health Policy GG.1808: Plan of Care, Long-Term Care
CC. CalOptima Health Policy GG.1830: In-Home Supportive Services (IHSS) Referral Coordination Process
DD. CalOptima Health Policy GG.1832: Multipurpose Senior Services Program (MSSP) - MSSP Identification, Referral, and Coordination of Care Process
EE. CalOptima Health Policy GG.1900: Behavioral Health Services
FF. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-005: No Wrong Door for Mental Health Services Policy
GG. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)
HH. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-030: Initial Health Appointment (Supersedes APL 13-017 and Policy Letters 13-001 and 08-003)

II. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-004: Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)
JJ. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-021: Population Needs Assessment and Population Health Management Strategy (Supersedes APL 19-011)
KK. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, May 2024
LL. Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)
MM. National Committee for Quality Assurance Standards and Guidelines

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/18/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/29/2023	Department of Health Care Services (DHCS)	File and Use
08/15/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	07/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	10/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	07/01/2024	GG.1667	CalAIM Population Health Management Program	Medi-Cal

IX. GLOSSARY

Term	Definition
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).
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 Manager	An individual identified as a single point of contact responsible for the provision of care management services for a member.
Case 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.
Children with Special Health Care Needs (CSHCN)	Children 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 generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).
Complex Case Management (CCM)	The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.
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.
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.

Term	Definition
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.
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.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network
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.
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.
Memorandum of Understanding (MOU)	An agreement between CalOptima Health and an external agency, which delineates responsibilities for coordinating care for Members.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
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 Committee (PHMC)	An advising committee that: 1. Provides overall direction for continuous process improvement and oversight of the Population Health Management (PHM) Program; 2. Ensures PHM activities are consistent with CalOptima Health's strategic goals and priorities; and 3. Monitors compliance with regulatory requirements.

Term	Definition
Population Health Management Strategy (PHMS)	A comprehensive plan of action for addressing Member needs across the continuum of care, based on annual Population Needs Assessment (PNA) results, data driven risk stratification, predictive analysis, identified gaps in care, standardized assessment processes, and holistic care management interventions. CalOptima Health is required to include, at a minimum, a description of how it will: 1. Keep all Members healthy by focusing on wellness and prevention services; 2. Identify and manage Members with high and rising-risk; 3. a separate section on Members less than twenty-one (21) years of age; 4. Ensure effective transition planning, across delivery systems or settings, through care coordination and other means to minimize patient risk and ensure appropriate clinical outcomes for Member; and 5. Identify and mitigate Member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance Health Equity.
Population Needs Assessment (PNA)	A process for: 1. Identifying Member health needs and Health Disparities; 2. Evaluating health education, Cultural and Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and 3. Implementing targeted strategies for health education, C&L, and QI programs and services.
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 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.
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
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.
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.
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.

Term	Definition
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.
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.
Third Party Entities	Local health departments, local educational and governmental agencies, such as county behavioral health departments for specialty mental health care and SUD services, and other local programs and services.
Transitional Care Services	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).