Policy:	GG.1830
Title:	**In-Home Supportive Services (IHSS) Referral Coordination Process**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 11/13/2024*
Effective Date:	01/01/2016
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines how CalOptima Health shall systemically identify and refer Members who may meet the eligibility criteria for In-Home Supportive Services (IHSS).

II. POLICY

A. CalOptima Health shall collaborate and coordinate In-Home Support Services (IHSS) for CalOptima Health Members with the Orange County Social Services Agency (SSA) in accordance with the Memorandum of Understanding (MOU) with the County of Orange SSA Related to IHSS. This includes referrals for IHSS and Member information sharing to ensure care coordination.

B. The CalOptima Health LTSS Department shall provide new referrals from CalOptima Health and Health Networks to the Orange County SSA IHSS division to ensure at-risk Members receive the home-based caregiving support needed to delay institutionalization.

C. SSA shall be responsible for completing the following tasks, including but not limited to:

1. Assessing (initial and annually), approving, and authorizing each IHSS recipient's initial and continuing need for services. Assessments by SSA may result in a specific number of hours to complete approved services such as personal care, light domestic housekeeping, accompaniment to medical appointments, protective supervision and paramedical services;

2. Performing quality assurance activities, including but not limited to, routine case reviews, home visits, and detection and reporting of suspected fraud;

3. IHSS Grievances and Appeals;

4. Participating in administrative fair hearings;

5. Delegating duties to the Public Authority (PA) and providing the PA with referral information of all IHSS Providers for the purposes of wages and benefits;

6. Pursuing overpayment recovery timecard errors; and

7. Maintaining an IHSS advisory committee.

C. CalOptima Health and its Health Networks shall review IHSS assessment reports for the High-Risk Members to identify:

1. Referrals to other community resources and other agencies for services outside the scope of CalOptima Health's responsibility that meets Member's social needs, such as transportation needs and preferences, mental and behavioral health services, personal care services, housing needs, home-delivered meals, energy assistance programs, and services for individuals with intellectual and developmental disabilities;

2. Referrals to other LTSS programs such as Community-Based Adult Services (CBAS) and Multipurpose Senior Services Program (MSSP) to support the Member's functioning and health status.

3. A need for including involvement of caregivers, identifying participant and caregiver preferences and having back-up plans in place for situations when caregivers are unavailable;

4. A Member's current health status and treatment needs and the need for facilitating communication among the Member's Long-Term Services and Supports (LTSS) and other Providers, including mental health and substance abuse Providers, when appropriate;

5. A Member's needs for providing other activities or services needed to assist Members in optimizing their health status, including assistance with self-management skills or techniques, health education, and other modalities to improve health status and meet personal goals.

6. Appropriate timeframes for follow up calls or reassessment, if appropriate, due to changes in circumstance or condition as in accordance with CalOptima Health Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

7. CalOptima Health shall track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until notified by the county that IHSS services are no longer needed.

8. CalOptima Health shall outreach and coordinate with the county IHSS agency for any Member identified by DHCS as receiving IHSS.

9. While Members receive IHSS, CalOptima Health shall provide Basic Population Health Management (BPHM) in accordance with GG.1667: CalAIM Population Health Management Program and Care Coordination of all Medically Necessary services in accordance with CalOptima Health Policies GG.1301: Comprehensive Care Management Process and MA.6009: Care Management and Coordination Process.

D. A Member or a Member's Authorized Representative may file a Grievance and Appeal to SSA regarding any decisions concerning their IHSS services in which they disagree. Upon receiving a Grievance or Appeal regarding IHSS services and hours, CalOptima Health shall refer a Member or a Member's Authorized Representative to file a Grievance or Appeal with SSA as governed by California law and regulations.

III. PROCEDURE

A. Eligibility for IHSS:

1. Required health care certification from a healthcare professional Provider (e.g., primary care physician, nurse practitioner, specialist);

2. Ability to live at home or a home of Member's own choosing; and

3. Able to remain safely at home with assistance.

B. CalOptima Health shall identify potential IHSS candidates in accordance with CalOptima Health Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessments.

C. CalOptima Health or Health Network staff, including primary care providers, hospitals, nursing facility staff, Members and/or a Member's caregiver may identify and refer CalOptima Health Members who could benefit from the IHSS Program to the CalOptima Health LTSS program pursuant to CalOptima Health Policies GG.1301: Comprehensive Care Management Process and MA.6009: Care Management and Coordination Process. Referrals may be submitted in multiple ways including through: Guiding Care activity, secure email, phone, fax, or completion of the In-Home Supportive Services Communication Form and submitting the form to the LTSS Department.

D. Once the referral is received, CalOptima Health LTSS is then responsible for submitting the In-Home Supportive Services Communication Form to SSA to initiate the initial IHSS application process.

E. The Orange County SSA shall be responsible for verifying and processing IHSS applications. Once the IHSS application intake process is completed, the IHSS social worker shall conduct an in-home, face-to-face assessment and make a determination whether to approve, modify or deny the application, including determination of authorized hours and tasks pursuant to Welfare and Institutions Code section 12300 et seq, and in accordance with SSA IHSS internal policy.

F. Initial and annual assessments, approving and authorizing each IHSS recipient's initial services and continuing need for services is the responsibility of the IHSS SSA staff according to the regulatory requirements.

G. Service Care Coordination

1. By January 1, 2024, CalOptima Health shall coordinate Member services with SSA IHSS in accordance with the MOU requirements set forth in the CalOptima Health Contract with the Department of Health Care Services (DHCS), including but not limited to:

    a. CalOptima Health is responsible for authorizing Medically Necessary Covered Services, ensuring network providers coordinate the provision of care for Members as provided in the applicable Medi-Cal managed care contract, and provide referrals to the County and coordinating services and other related Medi-Cal long-term services and supports provided by CalOptima Health and carve-out programs and benefits to Members.

2. CalOptima Health shall be responsible for oversight of MOU:

    a. CalOptima Health's LTSS Department shall meet with SSA IHSS staff at least quarterly;

    b. Report compliance with MOU to CalOptima Health's Compliance Officer;

    c. Ensure there is sufficient staff to support compliance with MOU;

d. Ensure an appropriate amount of leadership on MOU engagements from both CalOptima Health and IHSS;

e. Ensure training and education regarding MOU provisions are conducted annually; and

f. Designate a CalOptima Health-IHSS Liaison.

i. The liaison shall be trained and serve as the day-to-day liaison with SSA; and

ii. CalOptima Health shall notify SSA of any changes to the CalOptima Health-IHSS Liaison as soon as possible but no later than the date of change and shall notify DHCS within five (5) working days of the change.

3. Orange County Social Services Agency IHSS obligations:

a. SSA IHSS is responsible for addressing, approving and authorizing each Members initial and continuing need for IHSS pursuant to California Welfare and Institution Code Section 12300;

b. IHSS shall assign a responsible person to oversee compliance with this MOU; and

c. Assign a person to serve as the day-to-day Liaison with CalOptima Health. SSA shall notify CalOptima Health of changes to the IHSS Liaison as soon as possible but no later than the date of change.

4. CalOptima Health shall provide training and education in accordance with the MOU, including but not limited to:

a. Compliance with MOU;

b. Provide SSA with educational material related to accessing medically necessary services; and

c. In coordination with SSA, ensure CalOptima Health-IHSS Liaison is sufficiently trained on IHSS Assessment and referral processes and providers and how CalOptima Health and primary care providers can support IHSS eligibility application and care coordination across IHSS, medical services, and long-term services and supports.

5. Referrals:

a. CalOptima Health shall work collaboratively with SSA to ensure that Members are referred to SSA for IHSS and/or CalOptima Health for the appropriate services; and

b. By January 1, 2025, CalOptima Health and SSA shall develop a process to implement closed loop referrals to applicable community supports, Enhanced Care Management (ECM) benefits and/or community-based resources, in accordance with the CalAIM Population Health Policy Guide.

6. Care Coordination:

a. CalOptima Health and county IHSS shall share information per this policy to ensure there is no duplication of services for Members enrolled in ECM, Community Supports, and other covered services through IHSS and that services are provided in a coordinated,

complementary way. IHSS eligibility does not categorically preclude eligibility for ECM and Community Supports.

b. CalOptima Health shall ensure the continuation of basic Population Health Management and care coordination of all Medi-Cal benefits to be provided or arranged for by CalOptima Health while Members receive IHSS in accordance with CalOptima Health Policies GG.1667: CalAIM Population Health Management Program,GG.1301: Comprehensive Care Management Process, and MA.6009: Care Management and Coordination Process.

c. CalOptima Health shall outreach and coordinate with county IHSS, and to the extent possible the Member and IHSS provider, for Members identified by DHCS as receiving IHSS.

d. CalOptima Health shall assess Members transferring from one care setting or level of care to another, such as from hospital or nursing facility to home or community and make IHSS referral as appropriate as a part of transitional care services.

7. Quality Improvement:

a. CalOptima Health shall ensure quality improvement in accordance with CalOptima Health policy GG.1816: Quality Improvement Activities, Long-Term Services and Supports.

b. CalOptima Health shall utilize reports to track cross-system referrals, Member engagement, and service utilization and to prevent duplication of services rendered.

8. Data Sharing and Confidentiality:

a. CalOptima Health shall share Member's clinical information with the IHSS Social Worker including, but not limited to, health risk assessment results, hospital or skilled nursing facility admissions, emergency room visits, and Member's ICP as requested.

b. SSA IHSS Staff shall share with CalOptima Health Member's information relevant to development or modification of Member's IHSS service plan.

c. CalOptima Health shall review IHSS Summary reports and IHSS service plan and coordinate with the county IHSS agency to ensure Members do not receive duplicative services through Enhanced Care Management (ECM), Community Supports, and other services.

d. CalOptima Health and SSA shall maintain confidentiality of all records and information about Members pursuant to all applicable federal and/or state laws or regulations, the Health Insurance Portability and Accountability Act (HIPAA) on protected health information (PHI).

IV. ATTACHMENT(S)

A. IHSS Communication Form
B. Care Coordination Initiative (CCI) Communication Memo

V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services
B. Welfare and Institutions Code, §§ 12300.7, 12301.24, 12305.71, and 12305.81
C. CalOptima Health Policy GG.1301: Comprehensive Care Management Process

D. CalOptima Health Policy GG.1323: Senior and Persons with Disabilities and Health Risk Assessments
E. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
F. CalOptima Health Policy MA.6009: Care Management and Coordination Process

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/26/2016	Department of Health Care Services (DHCS)	Approved as Submitted
12/10/2019	Department of Health Care Services (DHCS)	Approved as Submitted
06/24/2021	Department of Health Care Services (DHCS)	Approved as Submitted
08/21/2023	Department of Health Care Services (DHCS)	Approved as Submitted
09/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted
10/31/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2016	GG.1830	In-Home Supportive Services (IHSS) Identification, Referral and Care Coordination Process	Medi-Cal OneCare Connect
Revised	03/01/2017	GG.1830	In-Home Supportive Services (IHSS) Identification, Referral and Care Coordination Process	Medi-Cal OneCare Connect
Revised	11/01/2019	GG.1830	In-Home Supportive Services (IHSS) Referral Coordination Process	Medi-Cal OneCare Connect
Revised	06/01/2020	GG.1830	In-Home Supportive Services (IHSS) Referral Coordination Process	Medi-Cal OneCare Connect
Revised	06/01/2021	GG.1830	In-Home Supportive Services (IHSS) Referral Coordination Process	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1830	In-Home Supportive Services (IHSS) Referral Coordination Process	Medi-Cal
Revised	03/01/2023	GG.1830	In-Home Supportive Services (IHSS) Referral Coordination Process	Medi-Cal
Revised	09/01/2023	GG.1830	In-Home Supportive Services (IHSS) Referral Coordination Process	Medi-Cal
Revised	10/01/2024	GG.1830	In-Home Supportive Services (IHSS) Referral Coordination Process	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: 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). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Authorized Representative	Medi-Cal: 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. OneCare: An individual who is the Legal Representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity. (Form CMS-1696 may not be used to appoint an Authorized Representative for the purposes of enrollment and disenrollment. This form is solely for use in the Claims Adjudication or Claim Appeals process, and does not provide broad legal authority to make another individual's healthcare decisions.)

Term	Definition
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.
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 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.
Covered Services	Medi-Cal: 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;

Term	Definition
	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. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
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 systemic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
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.
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.
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.
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.

Term	Definition
Long Term Services and Supports (LTSS)	Medi-Cal: 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.
Medically Necessary or Medical Necessity	Medi-Cal: 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 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 1396d(r)(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 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. OneCare: Reasonable and necessary medical 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 includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Multipurpose Senior Services Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 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.
Population Health Management	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.

Term	Definition
Provider	Medi-Cal: 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. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Public Authority	The Orange County IHSS Public Authority (PA) provides the elderly, blind, and individuals with disabilities assistance in finding a prescreened homecare Provider who will enable them to live independently and remain safely in their homes. Services offered by the Orange County IHSS Public Authority include: homecare registry, provider enrollment processing, training for IHSS consumers and providers, employer of record for IHSS provider wage collective bargaining with United Domestic Workers of America.