Policy:	MA.4008
Title:	**Member Handbook Requirements**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/16/2024*
Effective Date:	06/01/2005
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the content and distribution requirements of the OneCare Member Handbook.

II. POLICY

A. At the time of enrollment, CalOptima Health shall send the information to the Member on how to access the Member Handbook online and how to request a hard copy, in accordance with this policy.

B. Annually, CalOptima Health shall send information to the Member on how to access the Member Handbook online and how to request a hard copy.

C. CalOptima Health shall include the following information in the OneCare Member Handbook, as required by the Centers for Medicare & Medicaid Services (CMS):

1. Customer Service Department hours of operation, including Teletypewriter (TTY) and twenty-four (24) hour telephone numbers;

2. Copy and instructions for use of the Member Identification (ID) card;

3. Process for Member notification of changes in Covered Services or location of Covered Services;

4. Information on the OneCare service area;

5. Information on out-of-area coverage;

6. Covered Services;

7. Non-covered or excluded benefits and services;

8. Information on supplemental benefits;

9. Member procedures for:

a. Obtaining Covered Services:

    i. Primary Care Provider (PCP) appointments;

    ii. Process for referral to a specialist;

    iii. Process for self-referral services; and

    iv. Prior Authorization and review process.

b. Selecting or changing a PCP;

c. Requesting Medical Record transfer when changing a PCP;

d. Obtaining Emergency Services within and outside Orange County;

e. Obtaining after-hour or urgent services within and outside Orange County; and

f. Completing the Health Risk Assessment within ninety (90) calendar days after enrolling in OneCare, in accordance with CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment.

10. Summary of a Member's financial obligations, including applicable charges, Member cost sharing (such as co-payment, deductibles, and co-insurance), and any Member liability for balance billing;

11. Information regarding the prescription drug benefit including:

    a. Applicable conditions and limitations associated with the receipt or use of Covered Part D Drugs;

    b. The manner in which the Formulary functions, including any tiered Formulary structure and utilization management procedures;

    c. The process for obtaining a Coverage Determination Exception; and

    d. A description of the Medication Therapy Management (MTM) program.

12. Information on Emergency, Non-Medical and Non-Emergency Medical Transportation Services;

13. Advance Directive information;

14. Member Complaint, Grievance, and Appeal procedures, in accordance with CMS regulatory requirements as referenced in CalOptima Health Policies MA.6114: Medicare Part D Redeterminations, MA.9002: Enrollee Grievance Process, MA.9015: Standard Integrated Appeals, MA.9003: Standard Pre-Service Appeal, MA.9004: Expedited Pre-Service Integrated Appeal, and MA.9005: Payment Appeal.

15. Member rights and responsibilities, in accordance with CalOptima Health Policy MA.4001: Member Rights and Responsibilities;

16. Disenrollment rights and responsibilities, as set forth in CalOptima Health Policy MA.4004: Member Disenrollment;

17. Information on interpreter services, at no charge to the Member, including services for the hearing impaired, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services;

18. Information on available quality assurance programs;

19. Medicare enrollment and disenrollment process;

20. The fact that CalOptima Health may terminate or refuse to renew the Contract, or reduce the service area, and the effect of those actions on Members;

21. Glossary of terms; and

22. Other information as required by CMS.

III. PROCEDURE

A. CalOptima Health shall follow the CMS model Member Handbook and, when possible, make best efforts to write the OneCare Member Handbook at a sixth (6^{th}) grade reading level in languages set forth in CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

B. CalOptima Health shall ensure that the OneCare Member Handbook is professionally produced and presented in a clear, accurate, and standardized manner.

C. For voluntary enrollments CalOptima Health shall send the OneCare Summary of Benefits and information on how to access the Member Handbook online and how to request a hard copy to each newly eligible Member as follows:

1. When enrollment confirmation is received at least ten (10) calendar days prior to the end of the calendar month, the Member shall receive a Summary of Benefits and information on how to access the Member Handbook online and how to request a hard copy, no later than the last day of the calendar month prior to the Member's effective date.

2. When enrollment confirmation is received with less than ten (10) calendar days before the end of the calendar month, the Member shall receive a Summary of Benefits and information on how to access the Member Handbook online and how to request a hard copy, no later than ten (10) calendar days after receipt of the completed CMS confirmation of enrollment.

D. After initial enrollment, CalOptima Health shall send an Member Handbook upon request.

E. Annually, CalOptima Health shall send information on how to access the Member Handbook online and how to request a hard copy.

F. Upon request by a Member, CalOptima Health shall provide the OneCare Member Handbook in alternate formats to meet the need of the Member, free of charge.

IV. ATTACHMENT(S)

A. Member Handbook Notice Insert

V. REFERENCE(S)

A. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
B. CalOptima Health Policy MA.4001: Member Rights and Responsibilities
C. CalOptima Health Policy MA.4004: Member Disenrollment
D. CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment
E. CalOptima Health Policy MA.6114: Medicare Part D Redeterminations
F. CalOptima Health Policy MA.9002: Enrollee Grievance Process
G. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
H. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
I. CalOptima Health Policy MA.9005: Payment Appeal
J. CalOptima Health Policy MA.9015: Standard Integrated Appeals
K. Centers for Medicare & Medicaid Services (CMS) Model Member Handbook
L. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual
M. Title 42, Code of Federal Regulations (CFR), §§ 422.111, and 423.128(a) and (b)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2005	MA.4008	Evidence of Coverage	OneCare
Revised	01/01/2006	MA.4008	Evidence of Coverage	OneCare
Revised	03/01/2009	MA.4008	Evidence of Coverage	OneCare
Revised	09/01/2012	MA.4008	Evidence of Coverage	OneCare
Revised	02/01/2014	MA.4008	Evidence of Coverage	OneCare
Revised	07/01/2015	MA.4008	Evidence of Coverage	OneCare
Revised	08/01/2016	MA.4008	Evidence of Coverage	OneCare
Revised	07/01/2017	MA.4008	Evidence of Coverage	OneCare
Revised	11/01/2018	MA.4008	Evidence of Coverage	OneCare
Revised	10/01/2019	MA.4008	Evidence of Coverage	OneCare
Revised	02/01/2020	MA.4008	Evidence of Coverage	OneCare
Revised	03/01/2022	MA.4008	Evidence of Coverage	OneCare
Revised	12/01/2023	MA.4008	Member Handbook Requirements	OneCare
Revised	12/01/2024	MA.4008	Member Handbook Requirements	OneCare

IX. GLOSSARY

Term	Definition
Advance Directive	A written instruction such as living wills or durable powers of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State) and signed by the Member, that explains the Member's wishes concerning the provisions of health care if the Member becomes incapacitated and is unable to make those wishes known.
Appeal	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.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Complaint	Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Coverage Determination Exception	A Coverage Determination related to: 1. OneCare's tiered cost-sharing structure; or 2. A Part D Covered Drug that is not on the OneCare Formulary.
Covered Part D Drugs	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in section 1927(k)(2)© of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
Covered Service	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish Emergency Services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Health Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.
Grievance	An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Risk Assessment (HRA)	A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.
Medical Record	A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Medication Therapy Management (MTM)	A program of drug therapy management furnished by a pharmacist and that is designed to: 1. Assure that Covered Part D Drugs under OneCare are appropriately used to optimize therapeutic outcomes through improved medication use; and 2. Reduce the risk of adverse events, including adverse drug interactions.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Non-Emergency Medical Transportation (NEMT)	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Non-Medical Transportation (NMT)	Round trip transportation by passenger car, taxicab, or any other form of public or private conveyance (private vehicle) for Members who are able to ambulate without assistance.
Primary Care Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.

Term	Definition
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Urgent Care Services	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.