Policy:	MA.4007
Title:	**Member Disclosures**
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 requirements for disclosing information to Members that meet Centers for Medicare & Medicaid Services (CMS) standards.

II. POLICY

A. Prior to enrollment, each prospective dual-eligible enrollee is provided with the OneCare Summary of Benefits. This is a comprehensive written statement describing cost sharing protections and benefits that the individual is entitled to under the Medicare and Medicaid programs.

B. At the time of enrollment, and at least annually thereafter, CalOptima Health shall disclose the following information to a Member:

1. OneCare's Service Area;

2. Covered services offered under OneCare, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and to the extent it offers Part D as an MA-PD plan, and for purposes of comparison:

   a. The benefits offered under Original Medicare, including Covered Services, beneficiary cost sharing, and any beneficiary liability for balance billing; and

   b. The availability of the Medicare hospice option and any approved hospices in the Service Area.

3. How CalOptima Health meets access requirements, including the number, mix, and addresses of Providers from whom a Member may obtain Covered Services; each Provider's cultural and linguistic capabilities, including:

   a. Languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office;

   b. Any out-of-network coverage; and

   c. How OneCare meets the requirements for access to services offered under OneCare.

4. Out-of-area coverage provided under OneCare, including coverage provided to eligible Members who may reside outside the OneCare Service Area;

5. Coverage of Emergency Services, including:

    a. An explanation of what constitutes an emergency, referencing the definitions of Emergency Services and Emergency Medical Condition;

    b. The appropriate use of Emergency Services, stating Prior Authorization shall not be required;

    c. The process and procedures for obtaining Emergency Services, including the use of the 911telephone system or its local equivalent; and

    d. The locations where the Member may obtain Emergency Services, and other locations at which contracted Providers may provide Emergency Services and Post-Stabilization Care.

6. Any mandatory or optional supplemental benefits and copayments, if applicable;

7. Information about the OneCare Formulary, including:

    a. A list of drugs included in the Formulary;

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

    c. The process for obtaining a Coverage Determination Exception.

8. Prior Authorization rules and other reviews required to ensure payment for services, including instructions to the Members that, if a Non-Contracted Provider submits a bill directly to the Member, the Member should not pay the bill, but submit the bill directly to CalOptima Health for processing and determination of Member liability, if any;

9. All Grievance and Appeal rights and procedures;

10. A description of the Medication Therapy Management (MTM) Program;

11. A description of the quality assurance program; and

12. Disenrollment rights and responsibilities.

C. During any month in which a Member uses Covered Part D Drugs, CalOptima Health OneCare shall provide the Member with a written Explanation of Benefits (EOB), in a form easily understandable to the Member. The EOB shall include the following:

    1. A listing of the item or service for which CalOptima Health made payment;

    2. Amount of the payment for each item or service;

    3. Notice of the Member's right to an itemized statement;

    4. A cumulative, year-to-date statement of the total Part D benefits provided in relation to deductibles, initial coverage limits, and annual out-of-pocket thresholds;

5. Cumulative (year-to-date total) of incurred costs;

6. For low-income Members, information on the cumulative, year-to-date total of incurred costs including the CMS subsidy amounts that count toward incurred costs; and

7. Applicable Formulary changes.

D. Upon request by a Member, OneCare shall disclose the following information to the Member:

1. Benefits covered under Original Medicare;

2. Utilization control mechanisms;

3. Aggregated number and disposition of disputes, categorized by:

a. Grievances; and

b. Appeals.

4. A summary description of CalOptima Health's method of compensation for Providers;

5. Information regarding CalOptima Health's financial condition, including the most recently audited information, and a description of OneCare's financial condition; and

6. Information regarding Provider incentive plans that affects the use of referral services, also the type of incentive arrangement, and whether stop-loss protection is provided.

E. Upon request by a Member, OneCare shall assist a Member in obtaining the following information:

1. Benefits under Original Medicare, including covered benefits, beneficiary cost sharing, and any beneficiary liability for balance billing;

2. Information and instructions on how to exercise Election options;

3. A general description of procedural rights, including Grievance and Appeal procedures under Original Medicare and the Medicare Advantage program, and the right to be protected against discrimination based on factors related to health status;

4. A general description of the benefits, enrollment rights, and requirements applicable to Medicare supplemental policies, and provisions relating to Medicare select policies;

5. The fact that CalOptima Health may terminate or refuse to renew its contract with CMS, or reduce the Service Area included in its contract, and the effect that any of those actions may have on a Member; and

6. A list of Medicare Advantage plans that are, or will be, available to residents in the Service Area in the following calendar year, and information on the aspects described below, for each plan and in a manner that facilitates comparison among plans:

a. Benefits:

i. Covered benefits that are beyond those provided under Original Medicare;

ii. Any beneficiary cost sharing;

iii. Any maximum limitation on applicable out-of-pocket expenses;

iv. In the case of a Medicare Advantage private Fee-For-Service Plan, differences in cost sharing, enrollee premiums, and balance billing, as compared to Medicare Advantage plans;

v. The extent to which an enrollee may obtain benefits through out-of-network Providers;

vi. The types of Providers that participate in CalOptima Health's network, and the extent to which an enrollee may select among those Providers; and

vii. The coverage of Emergency Services and Urgent Care.

b. The Medicare Advantage monthly basic beneficiary premiums, the Medicare Advantage monthly supplemental beneficiary premium, and any reduction in Medicare Part B premiums;

c. CalOptima Health's Service Area;

d. Quality and performance indicators for benefits under a plan, to the extent they are available, and how they compare with indicators under Original Medicare, as follows:

i. Disenrollment rates for Medicare enrollees for the two (2) previous years, excluding disenrollment due to death or move of residence outside CalOptima Health's Service Area, calculated according to CMS guidelines;

ii. Medicare enrollee satisfaction;

iii. Health outcomes;

iv. Plan-level Appeal data;

v. The recent record of plan compliance with Medicare Advantage requirements; and

vi. Other performance indicators.

e. Whether or not CalOptima Health offers mandatory supplemental benefits, or offers optional supplemental benefits, and premiums and other terms and conditions for those benefits.

F. Upon request from a Part D eligible beneficiary for Part D coverage information, utilization, or Grievance information, CalOptima Health shall provide the following:

1. General coverage information including:

a. OneCare enrollment procedures, including information and instructions on how to exercise Election options; and

b. A general description of Member rights, including Grievance, Coverage Determination, Reconsideration, Exceptions, and Appeals procedures.

2. Benefits, including:

a. Covered Services;

b. Member cost-sharing, such as deductibles, coinsurance, and co-payment amounts, including cost-sharing for subsidy eligible individuals;

c. Any maximum limitations on out-of-pocket expenses;

d. The extent to which a Member may obtain benefits from Non-Contracted Providers;

e. Types of pharmacies in the Participating Pharmacy Network, and the extent to which a Member may select among those pharmacies; and

f. Non-Participating Pharmacy access.

3. Premiums;

4. OneCare Formulary, including:

a. An actual list of drugs included on the OneCare Formulary; and

b. For each drug, any cost-sharing tier information applicable to that drug and whether or not utilization management programs apply.

5. OneCare Service Area; and

6. Quality and performance indicators for Part D benefits, as determined by CMS, including:

a. CalOptima Health procedures to control utilization of services and expenditures;

b. Number of disputes, and the disposition in the aggregate, in a manner and form described by CMS, and categorized as:

i. Grievances;

ii. Appeals; and

iii. Coverage Determination Exceptions.

c. CalOptima Health's financial condition, including the most recently audited information regarding, at a minimum, a description of the financial condition of CalOptima Health.

G. CalOptima Health shall respond to a Member's or Part D eligible beneficiary's request for information in a timely manner.

H. CalOptima Health shall notify Members of changes in Covered Services, in accordance with CalOptima Health Policy MA.4011: Notice of Change in Location and Availability of Covered Services.

I. CalOptima Health shall update this policy, as necessary, based on changes in CMS requirements and in compliance with CalOptima Health's policy review process.

III. PROCEDURE

A. CalOptima Health shall provide a Member with information listed in this policy in the Summary of Benefits or Evidence of Coverage (EOC) prior to a Member's enrollment, and at least annually thereafter, in accordance with CalOptima Health Policy MA.4008: Evidence of Coverage.

B. CalOptima Health may delegate a Pharmacy Benefit Manager (PBM) to issue the Part D Explanation of Benefits (EOB) to Members.

C. CalOptima Health shall have mechanisms for providing specific information on a timely basis to current and prospective Members upon request. These mechanisms must include all of the following:

1. A toll-free customer service call center that meets all of the following:

a. Operate during normal business hours, at least from Monday through Friday, from 8:00 A.M. to 8:00 P.M.

b. Provide customer telephone service in accordance with standard business practices;

c. Provide thorough information about the Covered Services, including co-payments, deductibles, and network pharmacies to existing and prospective members;

d. If requested by the prospective Member, transfer to the OneCare sales and marketing department for enrollment assistance.

e. Direct calls pertaining to operational issues, such as claims processing, benefit coverage, claims submission, and claims payment, to the appropriate responsible department;

f. Provide service to non-English speaking and hearing or speech impaired Members; and

g. Follow an explicitly defined process for handling Member Complaints.

2. Limit average hold time to no longer than 2 minutes. The hold time is defined as the time spent on hold by callers following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting, before reaching a live person.

3. The OneCare Customer Service Department shall answer eighty percent (80%) of all incoming calls to the call center within thirty (30) seconds.

4. The OneCare Customer Service Department shall ensure an abandonment rate for all incoming calls to the call center of five percent (5%) or less.

5. The OneCare Customer Service Department shall ensure eighty percent (80%) of all incoming calls requiring interpreter services are answered within eight (8) minutes of reaching the customer service representative and be made available at no cost to the caller.

6. OneCare Customer Service Department shall ensure eighty percent (80%) of all incoming calls requiring Teletypewriter (TTY) services are answered within seven (7) minutes.

D. CalOptima Health shall maintain an internet website that:

1. Includes, at a minimum, the information specified in this policy;

2. Includes a current Formulary, updated at least once per calendar month; and

3. Provides current and prospective Members with at least sixty (60) calendar days' notice regarding the removal or change in the tier placement of a Covered Part D Drug on the Formulary.

E. Upon request, CalOptima Health shall provide responses, in writing, to requests from a Member or Part D eligible beneficiary for specific information.

F. A Member may contact the OneCare Customer Service Department to request information listed in this policy.

G. A Member may contact the OneCare Customer Service Department to request assistance in obtaining information provided by CMS listed in this policy.

H. CalOptima Health shall provide information disseminated as part of a plan description, as well as information disclosed upon Member request, in writing, unless the Member explicitly consents to receive such information electronically or by telephone.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Application from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Health Policy MA.4008: Member Handbook Requirements
C. CalOptima Health Policy MA.4011: OneCare Member Notification of Change in Location or Availability of Providers or Covered Services
D. Medicare Managed Care Manual, Chapter 4
E. Title 42, Code of Federal Regulations (CFR), §§ 422.111 and 423.128

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.4007	Member Disclosures	OneCare
Revised	01/01/2006	MA.4007	Member Disclosures	OneCare
Revised	01/01/2008	MA.4007	Member Disclosures	OneCare
Revised	09/01/2010	MA.4007	Member Disclosures	OneCare
Revised	08/01/2012	MA.4007	Member Disclosures	OneCare
Revised	02/01/2014	MA.4007	Member Disclosures	OneCare
Revised	07/01/2015	MA.4007	Member Disclosures	OneCare
Revised	08/01/2016	MA.4007	Member Disclosures	OneCare
Revised	07/01/2017	MA.4007	Member Disclosures	OneCare
Revised	04/01/2019	MA.4007	Member Disclosures	OneCare
Revised	01/01/2020	MA.4007	Member Disclosures	OneCare
Revised	03/01/2022	MA.4007	Member Disclosures	OneCare
Revised	12/01/2023	MA.4007	Member Disclosures	OneCare
Revised	12/01/2024	MA.4007	Member Disclosures	OneCare

IX. GLOSSARY

Term	Definition
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.
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	A decision made by the plan, or its delegated entity, on a request for coverage (payment or provision) of an item, service, or drug.
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 Drug	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)(C) 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.
Disclosure	Has the meaning in Title 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Election Period	The time during which an eligible individual may elect a Medicare Advantage (MA) plan or Original Medicare. The type of Election Period determines the effective date of MA coverage as well as the types of enrollment requests allowed.

Term	Definition
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
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.
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.
Medication Therapy Management (MTM) Program	A program of drug therapy management furnished by a pharmacist, and that is designed to: 1. Assure that Covered Part D Drugs under OneCare Connect are appropriately used to optimize therapeutic outcomes through improved medication use; and 2. Reduce the risk of adverse events, including adverse drug interactions.
Non-Contracted Providers	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Physician Medical Group.
Original Medicare	The traditional Medicare Fee-for-Service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
Participating Pharmacy	Any Pharmacy that is credentialed by and subcontracted to the Pharmacy Benefit Manager (PBM) for the specific purpose of providing Pharmacy services to Members.
Pharmacy	An area, place, or premises licensed by the State Board of Pharmacy in which the profession of Pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Pharmacy Benefit Manager (PBM)	An entity that provides Pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.

Term	Definition
Post-Stabilization Care	Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or under some circumstances, to improve or resolve the condition.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Prior Authorization (Pharmacy)	The Formulary restriction which requires approval from CalOptima Health before the requested medication is covered.
Provider	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.
Reconsideration	A review of an adverse Organization Determination, the evidence and findings upon which it was based, and any other evidence the parties submit or CalOptima Health or Centers for Medicare & Medicaid Services (CMS) obtains.
Service Area	A geographic area that for local Medicare Advantage (MA) plans is a county or multiple counties, and for MA regional plans is a region approved by Centers for Medicare & Medicaid Services (CMS) within which an MA-eligible individual may enroll in a particular MA plan offered by an MA organization. Each MA plan must be available to all MA-eligible individuals within the plan's Service Area. In deciding whether to approve an MA plan's proposed Service Area, CMS considers the following criteria: 1. For local MA plans: a. Whether the area meets the county integrity rule that a Service Area generally consists of a full county or counties. b. However, CMS may approve a Service Area that includes only a portion of a county if it determines that the partial county area is necessary, nondiscriminatory, and in the best interests of the beneficiaries. CMS may also consider the extent to which the proposed Service Area mirrors Service Areas of existing commercial health care plans or MA plans offered by the organization. 2. For all MA coordinated care plans, whether the contracting Provider network meets the access and availability standards set forth in section 422.112 of Title 42 of the Code of Federal Regulations. Although not all contracting Providers must be located within the plan's Service Area, CMS must determine that all services covered under the plan are accessible from the Service Area. 3. For MA regional plans, whether the Service Area consists of the entire region.
Teletypewriter (TTY)	A device that allows people who are deaf, hard of hearing, or have severe speech impairments to communicate over the phone.

Term	Definition
Urgent Care	Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations: 1. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment; or 2. In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.