Policy:	MA.1001
Title:	**OneCare Glossary of Terms**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Michael Hunn 01/29/2024*
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Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines terms used in CalOptima Health's OneCare policies and procedures, unless otherwise expressly stated.

II. DEFINITIONS

Abuse: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.

Access Controls: Controls that identify and authenticate a user to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a user is entitled to have.

Active Treatment Plan: Services provided under an individual treatment or diagnostic plan, supervised and evaluated by a physician, to improve a patient's condition and to diagnose a condition.

Activities of Daily Living (ADL): Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.

Acute Condition: A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

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.

Adverse Activity: A sanction, exclusion, suspension, revocation of licensure, or felony as a result of quality of care issues and Complaints.

Advertisement: A read, written, visual, oral, watched, or heard bid for, or call to attention. Advertisements can be considered communication or Marketing based on the intent and content of the message.

Advertising Material: Advertising materials primarily intended to attract or appeal to a potential plan sponsor enrollee. Advertising materials contain less detail than other Marketing Materials and may provide benefit information at a level to entice a potential enrollee to request additional information.

Alternate Formats: Alternate Formats are used to convey information to individuals with visual, speech, physical, hearing, and intellectual disabilities (e.g., braille, large print, and audio).

Aligned Enrollment: Per 42 C.F.R. Section 422.2, the Enrollment in a D-SNP of a full-benefit Dual Eligible Beneficiary whose Medi-Cal benefits are covered under a Medi-Cal managed care organization contract under section 1903(m) of the Social Security Act between California and D-SNP MA organization, which is the parent organization, or another entity that is owned and controlled by D-SNP parent organization.

Ambulatory Surgical Center (ASC): A facility other than a hospital that provides outpatient surgery.

Annual Deductible: The amount of loss a Health Network must sustain for each Member in each Reinsurance Contract Year for each category of coverage before any benefit becomes payable.

Annual Election/Enrollment Period (AEP): An Election Period that takes place from October 15 through December 7 of every year.

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.

Applicable Integrated Plan: Per 42 CFR section 422.561, the Medi-Cal managed care organization through which D-SNP Contractor, its parent organization, or another entity that is owned and controlled by its parent organization, covers Medi-Cal services for Dual Eligible Beneficiaries enrolled with D-SNP Contractor and such Medi-Cal managed care organization.

Application Date: For paper enrollment forms and other enrollment request mechanisms, the Application Date is the date the enrollment request is initially received by the organization as defined by the method of enrollment. Plans must use this date in the appropriate field when submitting enrollment transactions to Centers of Medicare & Medicaid Services (CMS). For requests submitted to sales agents, including brokers, the Application Date is the date the agent/broker receives (accepts) the enrollment request and not the date the organization receives the enrollment request from the agent/broker. For purposes of enrollment, receipt by the agent or broker employed by or contracting with the organization, is considered receipt by the plan, thus all CMS required timeframes for enrollment processing begin on this date.

Appropriately Qualified Health Care Professional: A PCP, specialist, or other licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, or condition associated with the request for a Second Opinion.

Assignment (Pharmacy): Any of the following:

1. Change of more than twenty-five percent (25%) of the ownership or equity interest in a Pharmacy (whether in a single transaction or in a series of transactions);
2. The merger, reorganization, or consolidation of a Pharmacy with another entity with respect to which the Pharmacy is not the surviving entity; or

3. A change in the management of a Pharmacy from management by persons appointed or otherwise selected by the governing body of the Pharmacy (e.g., the Board of Directors) to a third-party manager or management company.

At-Risk Beneficiary (ARB): A Part D eligible individual who is determined to be at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs at *42 CFR* 423.153(f). Additional guidance about Part D drug management programs is available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html (Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Audit: A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.

Audit (Pharmacy): Any review or audit of a Pharmacy performed by CalOptima Health, CalOptima Health's authorized representative, or by any regulatory or law enforcement agency, except, however, any review or audit of a Pharmacy conducted by the PBM or its designee.

Augmentation and Alternative Communication Device (AAC): A set of tools and strategies that a Member uses to solve every day communicative challenges, including but not limited to, speech, a shared glance, text, gestures, facial expressions, touch, sign language, symbols, pictures and speech generating devices.

Authorization: Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent Authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code section 14100.2.

Authorization Request: A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner's office.

Authorized Representative/Legal Representative: An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, 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 (see §40.2.1). 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.

Authorized Representative (HIPAA): Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.

Automatic Orthopedic Positioning Device (AOPD): A non-standard positioning device (car sear and/or harness/vest) for use in a motor vehicle. An AOPD is designed to hold a larger child (over 40 pounds or over 40 inches in length) who requires positioning options such as pad that assist in head and truck positioning while being transported in a motor vehicle.

Basic Case Management (Care Management Level): A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Member's health and functional needs. Services are provided by the Primary Care Physician (PC) or by a PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of services outside the health plan, such as community social services or specialty mental health or Drug Medi-Cal services, are considered basic case management services.

Behavioral Health Services: Services which encompass both Mental Health and Substance Use Disorder services.

Benchmark: Performance information used to identify the operational and clinical practices that lead to the best outcome.

Board Members: Members of the CalOptima Health Board of Directors.

Brand Name Drug: A drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(c)), including an application referred to in section 505(b)(2) of the Federal Food, Drug and Cosmetic Act (21 USC 355(b)(2)).

Breach: Has the meaning in Title 45, Code of Federal Regulations Section 164.402.
Breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information.

Breach excludes:

1. Any unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of this part.
2. Any inadvertent disclosure by a person who is authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under subpart E of this part.
3. A disclosure of protected health information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Business Associate: Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who:

1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or
2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves

the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

A covered entity may be a business associate of another covered entity.

Business associate includes:

1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.
2. A person that offers a personal health record to one or more individuals on behalf of a covered entity.
3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Business Transaction: Any of the following kinds of transactions:

1. Sale, exchange, or lease of property;
2. Loan of money or extension of credit; or
   Goods, services, or facilities furnished for a monetary consideration including management services, but not including:

   a. Salaries paid to employees for services performed in the normal course of their employment; or
   b. Health services furnished to Members by hospitals and other providers, and by OneCare staff, medical groups, or independent practice associations, or by any combination of those entities.

CalOptima Health Program: A managed care program operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.

CalOptima Health Workforce: This includes any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

Cancellation of Enrollment Request: An action initiated by the beneficiary to cancel an enrollment request. To be valid, the cancellation request must be received by the organization before the enrollment effective date. An enrollment request that has been appropriately cancelled is considered not to have been used and the election remains available for use within the time frame of the applicable election period.

Capitation Payment: The monthly amount paid to a Health Network by CalOptima Health for the delivery of Covered Services to Members in that Health Network.

Capitation Rate: The percent of the gross Capitation Payment and any applicable premiums that CalOptima Health receives from Centers of Medicare & Medicaid Services (CMS) or Members on behalf of Members enrolled in a Health Network that is allocated to the Health Network for the delivery of Covered Services.

Care Coordination (or Coordination of Care): The identification of a medical condition or services that are not covered by OneCare under whose authority CalOptima Health operates. Encompasses services included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning and are included as part of a functioning Medical Home. A process used by a person or team to assist Members in accessing Medicare and Medi-Cal Services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness, and positive outcomes.

Care Coordination (Care Management Level): Case management provided to Members who are at moderate risk, but still have an acute or chronic medical condition that requires assessment and coordination of resources in order to maintain the Members in the least restrictive setting; it is provided by the Member's Health Network, in collaboration with their PCP.

Care Coordinator: a clinician or other trained individual who is employed or contracted by the Member's primary care provider or D-SNP, serves on one (1) or more Interdisciplinary Care Teams (ICT), and coordinates and facilitates meetings and other activities of those ICTs, as well as participates in the Health Risk Assessment of each Member on whose ICT they serve.

Care Management and Coordination: A collaborative process of assessment, planning facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

Case Management: A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Case Review: Review and disposition of concerns referred to the Quality Improvement Department for potential Quality of Care (QOC) or Quality of Service (QOS) issues.

Category A Experimental Device: A device for which absolute risk of the device type has not been established, that is, initial questions of safety and effectiveness have not been resolved, and the Food and Drug Administration (FDA) is unsure whether the device type can be safe and effective.

Category B Non-experimental/investigational Device: A device for which the incremental risk is the primary risk in question, that is, initial questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained Food and Drug Administration (FDA) premarket approval or clearance for that device type.

Center of Excellence: Facilities that are approved by the California Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) to provide specific transplant services.

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.

Certified Nurse Midwife: A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of women.

Certified Nurse Practitioner: A Certified Nurse Practitioner can provide a full range of primary, acute and specialty health care services, including but not limited to primary care, adult health, neonatal health, gerontology health, etc.

Certified Site Reviewer (CSR): A Physician or a registered nurse (RN) who is responsible for conducting Practitioner Site Review. Only a Physician or a RN CSR is qualified to sign the site review survey and medical record review survey documents (MMCD policy letter 02-02). A Trainer or a Master Trainer is responsible for training and certifying a CSR.

Cervical Intraepithelial Neoplasia: Changes of the cells in the cervix area that may be a precursor to cancer.

Chain Pharmacy: Multiple licensed retail Pharmacies operated under a single business name and logo in a standardized manner, which follow a uniform set of policies and procedures covering all aspects of their operation, and which are organized under a single ownership and management structure (definition excludes franchises).

Chronic Health Condition: A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.

Chronic Care: A multi-disciplinary and continuum of care 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 evidence-based practice guidelines and Member empowerment strategies such as self-management; and
3. Continuously evaluates clinical, humanistic, and health outcomes with the goal of improving Member well-being.

Claims Resubmission: The process by which a Provider requests CalOptima Health to re-review an initial claim outcome.

Class I recall: A situation in which there is a reasonable probability that the use of or exposure to a product will cause serious adverse health consequences or death.

Class II recall: A situation in which use of or exposure to a product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

Clean Claim: A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare.

Clean Claim (Part C Only): As defined at 42 CFR §422.500(b), a claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with 42 CFR §422.310(d)), or particular circumstance requiring special treatment that prevents timely payment and that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare.

Clinical Practice Guidelines (CPGs): Systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific circumstances.

Clinical Risk Level: The level of risk for clinical deterioration assigned to a Member through a stratification process involving a comprehensive review of clinical data. There are five (5) Clinical Risk Levels. Members identified as having Clinical Risk Level five (5) is at the highest risk for clinical deterioration. Members identified as having Clinical Risk Level one (1) is at the lowest risk for clinical deterioration.

Clinical Trials: Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics:

1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes;
2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;

3. The Clinical Trial does not unjustifiably duplicate existing studies;
4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial;
5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial;
6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and
7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.

Closed Pharmacy: A licensed Pharmacy that is not open to the general public, but either provides Pharmaceutical Services to select patient populations that reside in one (1) or more state-licensed facilities, or to patients residing in their homes, excluding Mail Order Pharmacies and Internet Pharmacies.

CMS Contract: CalOptima Health's written agreement with the Centers for Medicare & Medicaid Services (CMS) to provide Covered Services under OneCare.

Co-branding: Co-branding is defined as a relationship between two or more separate legal entities, one of which is an organization that sponsors a Medicare plan. Co-branding means when the Plan/Part D Sponsor displays the name(s) or brand(s) of the co-branding entity or entities on its marketing materials to signify a business arrangement. Co-branding arrangements allow a Plan/Part D Sponsor and its co-branding partner(s) to promote enrollment in the plan. Co-branding relationships are entered into independent of the contract that the Plan/Part D Sponsor has with CMS.

Code of Conduct: The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, employees, contractors, and agents are required to adhere.

Common Working File (CWF): The file that contains Medicare beneficiary information including eligibility, End Stage Renal Disease (ESRD), working aged and hospice data, and utilization, that can be utilized by a Medicare Advantage organization. The CWF facilitates the submittal of enrollment and other membership data to Centers of Medicare & Medicaid Services (CMS).

Community Partner: A CalOptima Health employee who is a liaison between CalOptima Health and the community and acts as an advocate for CalOptima Health Members. Such employee performs education, marketing, and enrollment tasks for CalOptima Health programs and shall possess California Department of Insurance (DOI) licensure, required to be renewed every 2 years.

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.

Complaint Process: The process by which CalOptima Health addresses and resolves all Complaints.

Completed Election: An enrollment request is considered complete when:

1. The form/request is signed by the beneficiary or legal representative (refer to §40.2.1 for a discussion of who is considered to be a legal representative), or the enrollment request mechanism is completed;
2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the Medicare Advantage organization (see below for definition of "evidence of Medicare Part A and Part B coverage");
3. All necessary elements on the form are completed (for enrollments, see Appendix 2 for a list of elements that must be completed) or when the enrollment request mechanism is completed as CMS directs, and, when applicable;

4. Certification of a legal representative's authority to make the enrollment request is obtained by attestation (refer to §40.2.1).
5. For Special Needs Plans (SNP), verification of SNP eligibility, as described in §20.11. Chronic condition SNPs (C-SNP) that utilize a CMS-approved pre-enrollment qualification assessment tool will consider the enrollment request to be complete upon receipt of the completed tool.

If an individual is involuntarily disenrolled for failure to pay premiums, to re-enroll in that plan, or enroll into another, he or she would need to request enrollment during a valid enrollment period. In addition, for enrollments into an MA-only (non MA-PD) plan, an MA organization may also choose to wait for the individual's payment of the plan premium, including any premiums due the MA organization for a prior enrollment before considering an enrollment "complete."

Complex Case Management: 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 (Care Management Level): Case Management provided to Members who are at high-risk; defined as having medically complex conditions that include the following but is not limited to:

1. Spinal injuries;
2. Transplants;
3. Cancer;
4. Serious Trauma;
5. AIDS;
6. Multiple chronic illness; or
7. Chronic illnesses that result in high utilization.

Compliance Committee: The CalOptima Health committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima Health's Compliance Program.

Compliance Program: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.

Comprehensive Health Risk Assessment (CHRA): A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period. The weighted scoring of the answers stratifies health interventions based on the overall score. CHRA is further addressed in CalOptima Health OneCare Policy MA.6022: Comprehensive Health Risk Assessment.

Comprehensive Outpatient Rehabilitation Facility (CORF): A CORF is a facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician.

Concurrent Drug Utilization Review (CDUR): A review of the prescribed drug therapy before each prescription is dispensed to an enrollee in a sponsor's Part D plan.

Concurrent Review: Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent Reviews are typically associated with inpatient care or

ongoing ambulatory care (i.e., allergy injections, physical therapy visits, or chemotherapy treatments) and are conducted to determine the medical necessity for continuing that care.

Confidential: Entrusted with private or personal information that is confined to a person or group as opposed to the public.

Confidential Information: Specific facts or documents identified as “confidential" by any law, regulations or contractual language.

Confidential Communications: The provision of communications of Protected Health Information (PHI) by alternative means or at alternative locations based upon a Member’s reasonable request.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): A multiyear initiative of the Agency for Healthcare Research and Quality to support and promote the assessment of consumers’ experiences with health care by developing standardized patient questionnaires that can be used to compare results across sponsors and over time and generate tools and resources that sponsors can us to produce understandable and usable comparative information for both consumers and health care providers.

Continuity of Care: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes:

1. Linkages between primary and specialty care;
2. Coordination among specialists;
3. Appropriate combinations of prescribed medications;
3. Coordinated use of ancillary services;
4. Appropriate discharge planning; and
5. Timely placement at different levels of care including hospital, skilled nursing and home health care.

Contracted Membership: For a Health Network, Contracted Membership shall mean the Members enrolled in such Health Network. For a Provider, Contracted Membership shall mean the Members who receive Covered Services from such Provider.

Contracted Pharmacy Network: Licensed pharmacies, including retail and institutional pharmacies, under contract with a Part D Sponsor to provide covered Part D drugs at negotiated prices to Part D enrollees.

Contracted Provider: A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks.

Coordination of Benefits (COB) (General): A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first. Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.

Coordination of Benefits (COB) (Pharmacy): When a Part D enrollee has other prescription drug coverage, COB allows each of the plans that provide coverage for this same beneficiary to determine their respective payment responsibilities.

Corrective Action Plan (CAP): A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.

Coverage Decision Letter: For integrated organization determination denials, applicable integrated plans must use the approved integrated denial notice, rather than the standard Integrated Denial Notice when issuing written denial notices to enrollees. The standardized integrated denial notice for applicable integrated plans is the Applicable Integrated Plan Coverage Decision Letter (Form CMS-10716), also known as the Coverage Decision Letter.

Coverage Determination (General): 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 (CD) (Pharmacy): Any decision made by CalOptima Health regarding:

1. Receipt of, or payment for, a prescription drug that a Member believes may be covered;
2. A tiering or Formulary Exception request;
3. The amount that the plan sponsor requires a Member to pay for a Part D prescription drug and the Member disagrees with the plan sponsor;
4. A limit on the quantity (or dose) of a requested drug and the Member disagrees with the requirement or dosage limitation;
5. A requirement that a Member try another drug before the plan sponsor will pay for the requested drug and the Member disagrees with the requirement; and
6. A decision whether a Member has, or has not, satisfied a Prior Authorization or other Utilization Management requirement.

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 Entity: A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.

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 Services: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract, or Care Coordination or Coordination of Care as defined in the State Medicaid Agency Contract.

Credentialing: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.

Credentialing and Peer Review Committee (CPRC): The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement (QI) Committee.

Credentialing Verification Organization (CVO): An organization that collects and verifies credentialing information.

Criteria: Clinical statements that help determine the appropriateness of a proposed medical intervention. Criteria are an objective tool used to support a clinical rationale for decision-making and are an integral component of a utilization management program. Criteria also aid in protecting against over-utilization and under-utilization of clinical resources. Criteria are:

1. Clinically-based on best practice, clinical data. and medical literature;
2. Patient-specific, allowing for each patient's presentation to be considered; and
3. Objective, rule-based, and reliable, allowing for consistently replicable reviews.

Critical Incident: Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial harm to the physical or mental health, safety or well-being of a member.

Cultural and Linguistic (C&L) Services: Services that promote equal access to health care services and are responsive to a Member's cultural and linguistic needs. These services include, but are not limited to:

1. Recruiting bilingual employees for appropriate positions whenever possible, and enhancing employees' bilingual skills and cultural sensitivity through employee development programs;
2. Providing twenty-four (24)-hour access to interpreter services at Key Points of Contact for all Members;
3. Providing translations of informational materials in Threshold Languages, providing oral translation for other languages upon request or as needed, and providing information and materials to meet the needs of Members with sensory impairments; and
4. Referring Members to culturally and linguistically appropriate community services, as needed.

Cultural Competency: The ability to actively apply knowledge of cultural behavior and linguistic issues when interacting with Members from diverse cultural and linguistic backgrounds. Essential elements of Cultural Competency include, but are not limited to:

1. An unbiased attitude and organizational policy that values and respects cultural diversity; respect for the multifaceted nature and individuality of people;
2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about health, illnesses and diseases, as well as differing communication patterns;
3. Recognition of the diversity among Members;
4. Skills to communicate effectively with diverse populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care;
5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socio-economic status, physical or mental ability, gender, sexual orientation, age, or disability;
   Programs and policies that address the health needs of diverse populations; and
6. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of the Members.

Current Procedural Terminology (CPT) Codes: Medical nomenclature used to report medical procedures and services under public and private health insurance programs.

Custom Seating System: Wheelchairs and modifications and accessories for wheelchairs with by-report pricing due to unique manufacture price lists.

D-SNP Contract: The written agreement between the Department of Health Care Services (DHCS) and CalOptima Health.

Deemed Status: Designation that a Medicare Advantage (MA) organization has been reviewed and determined "fully accredited" by a Centers of Medicare & Medicaid Services (CMS) approved accrediting organization for those standards within the deeming categories that the accrediting organization has the authority to deem.

Deeming Authority: The authority granted by Centers of Medicare & Medicaid Services (CMS) to accrediting organizations to determine, on CMS's behalf, whether a Medicare Advantage organization evaluated by the accrediting organization is in compliance with corresponding Medicare regulations.

De-identified Information: Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be used to identify a Member.

Delegation Agreement: Mutually agreed upon document, signed by both parties, which includes, without limit:

1. CalOptima Health responsibilities;
2. Duration of the agreement;
3. Termination of the agreement;
4. Delegated Entity responsibilities and Delegated Services;
5. Types and frequency of reporting to the Delegated Entity;
6. Process by which the CalOptima Health evaluates the Delegated Entity's performance (performance measurements);
7. Use of confidential CalOptima Health information including Member protected health information (PHI) by the Delegated Entity; and
8. Remedies available to the CalOptima Health if the Delegated Entity does not fulfill its obligations.

Delegation Oversight Committee (DOC): A subcommittee of the Compliance Committee chaired by the Director of the Audit & Oversight Department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.

Delegated Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

Delegated Services: Services delegated to a Delegated Entity through a Delegation Agreement, which may include, but are not limited to, administration and management services, marketing, utilization management, quality assurance, case management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, disenrollment, billing, sales and adjudicating organization determinations and appeals.

Dementia Care Specialist: D-SNP care coordinators/managers trained in understanding Alzheimer's disease and related dementias, symptoms, and progression; understanding and managing behaviors and communication problems; understanding caregiver stress and its management; and connecting enrollees and caregivers to community resources.

Denial of Participation: An action taken by CalOptima Health that excludes a Practitioner, a facility, or a vendor from further participation in the CalOptima Health Program. The scope is limited to those entities that are notified in advance of provision of future services to Members in accordance with current policies and procedures.

Department of Health Care Services (DHCS): The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Department of Health and Human Services (DHHS): The federal agency responsible for management of the Medicare and Medicaid programs.

Designated Record Set (DRS): Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is:

1. The medical records and billing records about individuals maintained by or for a covered health care provider;
2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

Designee: A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Detailed Notice of Medicare Non-coverage: A document that includes a detailed explanation of why CalOptima Health determined that coverage for services currently being received should end. It is given to Members only when the Member requests an expedited Organization Determination.

Direct Referral Authorization: Any referral from a Practitioner or Provider to a service or specialist that does not require an authorization or approval from any other entity before the Member can be seen or receive the specific service (does not pertain to Emergency Services).

(DHCS) Director: The Director of the California Department of Health Care Services.

Disability: A physical or mental condition that limits a person's movements, senses, or activities.

Disclosure: Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations including the following: the release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.

Dismissal: Includes a decision not to review a request for an integrated grievance, integrated appeal, or integrated organization determination because it is considered invalid or does not otherwise meet the requirements for a request for integrated grievance, integrated appeal, or integrated organization determination. Subject to the guidance in this Addendum (see, for example, Section 20.2.a and Section 50.9.1.a), wherever the Part C & D Guidance refers to a "Dismissal," the statements and guidance apply equally to integrated grievances, integrated appeals, and integrated organization determinations for applicable integrated plans.

Document Review: CalOptima Health's examination of policies, procedures, and other written materials documenting a Contracted Provider's performance and compliance with respect to statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to the CalOptima Health program. Document Review may be conducted off-site at the CalOptima Health offices, or on-site at a Contracted Provider's place of business.

Downstream Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

Dual-Eligible Beneficiary (or Enrollee): An individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan. This Contract is only for full-benefit Dual-Eligible Beneficiaries (QMB+, SLMB+ and other full benefit Dually Eligible Beneficiaries).

Dual Eligible Special Needs Plan (D-SNP) Contract: Means this written agreement between DHCS and the D-SNP Contractor.

Duplicate Payment (Pharmacy): Any Part D payment made where the date filled is within the dates of the Member's hospice election and the drug payment is the responsibility of the Part A hospice benefit.

Duplicative Information: The same information contained in different formats. For example, information translated from a non-standard diagnosis of "chronic obstructive lung disease" into its standardized ICD-10 code is considered Duplicative Information.

Durable Medical Equipment (DME): Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that:

1. Can withstand repeated use.
2. Is used to serve a medical purpose.
3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly.
4. Is appropriate for use in or out of the patient's home.

Educational Event: Designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs and do not include Marketing (i.e., the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans).

Effective Date of Coverage/Enrollment: The date on which an individual's coverage in an MA plan begins.

Effectuation: Authorization or provision of a benefit that CalOptima Health has approved, payment of a claim or compliance with a complete or partial reversal of CalOptima Health's original adverse determination.

Election/Enrollment: Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.

Election/Enrollment 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.

Electronic Medical Record (EMR): A computerized medical record created in an organization that delivers care, such as a hospital and doctor's office. Electronic medical records tend to be a part of a local stand-alone health information system that allows storage, retrieval and modification of records. The electronic medical is similar to the paper based medical record and has the same ethical and legal protections.

Eligible Expenses: Reasonable and customary charges incurred at the time of service for which benefits are paid by the Health Network, and which are not otherwise excluded or limited under the reinsurance program between CalOptima Health and the Health Network. Eligible Expenses include all Covered Services which are the financial responsibility of the Health Network described in the OneCare Health Network Services Agreement.

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.

Encounter: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.

Encryption: The use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.

End Stage Renal Disease (ESRD): That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease: This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.

Enrollee: An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).

Enrollment: The process by which a beneficiary eligible for enrollment, as contained in Exhibit A, Attachment 1, Provision 8, and becomes a Member of CalOptima Health's D-SNP.

Enrollment Materials: Materials used to enroll or disenroll a beneficiary from a plan, or materials used to convey information specific to enrollment and disenrollment issues such as enrollment and disenrollment notices.

Electronic Protected Health Information (EPHI): Has the meaning in Title 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.

Escheat: The power of a state to acquire title to property for which there is no owner.

Evidence Based: A document or recommendation created using unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.

Excluded or Exclusion: Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.

Exclusively Aligned Enrollment: DHCS has limited enrollment in a D-SNP to full-benefit dual eligible individuals who are enrolled in a D-SNP for their Medicare benefits and a MCP for their Medi-Cal benefits, and the D-SNP and MCP are both owned and controlled by the same parent organization.

Expedited Grievance: A Grievance involving:

1. CalOptima Health's decision to invoke an extension relating to an Organization Determination or a Reconsideration; or
2. CalOptima Health's refusal to grant a Member's request for an Expedited Organization Determination or Reconsideration.

Expedited Organization Determination (EOD): A determination that must be made within seventy-two (72) hours of receipt of the request for a health care service from a Member, an Authorized Representative, or a physician if:

1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum life function; or
2. If a physician is requesting an expedited decision or is supporting a member's request for an expedited decision.

Expedited Service Appeal: A Service Appeal in which the thirty (30) calendar day process could seriously jeopardize the Member's life, health, or ability to regain maximum function.

Experimental Services: Drugs, equipment, procedures, or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans.

Explanation of Benefits (EOB): An ad hoc communication that provides Members with clear and timely information about their medical claims to support informed decisions about their healthcare options.

Explanatory Marketing Materials: A subset of Marketing Materials primarily intended to explain the benefits, operational procedures, cost sharing, and/or other features of a plan sponsor to current Members or to those considering enrollment. Explanatory marketing materials are further subdivided into enrollment materials, pre-enrollment marketing materials and post-enrollment marketing materials.

Extended Referral: A referral to a specialist for more than one (1) visit, where the Member's condition or disease requires specialized medical care over a prolonged period of time and is life-threatening, degenerative or disabling, and requires a specialist to coordinate the Member's health care (including some or all primary care).

FACETS™: Licensed software product that supports administrative, claims processing and adjudication, membership data, and other information needs of managed care organizations.

Facility: any premise that is:
A. Owned, leased, used or operated directly or indirectly by or for CalOptima Health or its affiliates for purposes related to the D-SNP Contract, or
B. Maintained by a Provider to provide services on behalf of CalOptima Health.

Facility Services: The room charge, supplies, equipment, and ancillary services associated with the provision of a medical procedure to a Member in an inpatient or outpatient hospital facility or Ambulatory Surgical Center (ASC).

Facility Site Review (FSR): A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume specialist physician offices.

Facility Site Review (FSR) – Ancillary Services: Ancillary services refers to diagnostic and therapeutic services such as, but not limited to radiology, imaging, cardiac testing, kidney dialysis, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary testing, audiology, and laboratory draw stations.

Facility Site Review (FSR) – CBAS: For purposes of this tool, CBAS services include professional nursing services, personal care services and/or social services, therapeutic activities, one meal per day, and additional services as specified on a Member's Individual Care Plan.

FDR: First Tier, Downstream or Related Entity.

Financial Security Instrument(s): Time certificates of deposit, irrevocable standby letters of credit, or surety bonds naming CalOptima Health as the beneficiary.

First Tier Entity (FTE): Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

Focused Review: An episodic examination of identified areas of a Contracted Provider's performance or component thereof.

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.

Formulary Management: Refers to the overall management of Medicare prescription drug formularies through utilization management activities and evidence-based reviews carried out by Pharmacy and Therapeutics (P&T) Committees with oversight from the Centers for Medicare & Medicaid Services (CMS) as outlined in the Medicare Modernization Act.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Free Standing Birth Center: Defined by Title 42, United States Code, Section 1396d(I)(3)(B) as a health facility-

1. That is not a hospital;
2. Where childbirth is planned to occur away from a pregnant woman's residence;
3. That is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and
4. That complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.

Full Scope Practitioner Office Site Review: An onsite inspection to evaluate the capacity or continuing capacity of a PCP site to support the delivery of quality health care services using the Practitioner Office Site Review and Medical Record Review.

Furnishing Number: A number issued by the California Board of Registered Nursing that enables Nurse Practitioners and Nurse Midwives to furnish drugs and devices in accordance with the Nursing Practice Act.

Generic Dispensing Rate: The number of generic drugs dispensed to Members divided by the total number of drugs dispensed within a given time period.

Generic Drug: A drug for which an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 USC 355(j)) is approved.

Good Cause: This term refers to the standards established in § 60.3.4 under which an individual may be reinstated into his/her MA plan when involuntarily disenrolled for failure to pay the plan's premium or the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) premium amount.

Grievance:
(CMS) 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.

(DHCS) Any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of CalOptima Health's or provider's operations, activities, or behavior regardless of whether remedial action requested.

Grievance and Appeals Resolution Services Committee (Grievance Committee): The CalOptima Health committee that reviews CalOptima Health's Grievance activities and reports to the CalOptima Health Quality Improvement (QI) Committee. The Grievance Committee members include CalOptima Health's:

1. Chief Operation Officer;
2. Chief Medical Officer;
3. Executive Director OneCare;
4. Director Health Services;
5. Customer Service Department Director or designee;
6. Compliance Department Director or designee;
7. Executive Director CalOptima Health Care Network;
8. Quality Management and Improvement Department Manager or designee; and
9. Grievance and Appeal Resolution Services Manager or designee.

Health Care Operations: Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.

Health Educator: A person who shall be educated and trained in the development and presentation of instruction of health education information. The Health Educator shall be capable of developing, presenting, and instructing Members about health education topics.

Health Insurance Portability and Accountability Act (HIPAA): The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.

Health Maintenance Organization (HMO): A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.

Health Network: A Physician Hospital Consortium (PHC), physician group under a shared risk contract, 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.

Health Network Service Agreement: The written agreement between CalOptima Health and a Health Network to provide Covered Services to Members.

Health Plan Management System (HPMS): A web-enabled information system that serves a critical role in supporting the implementation and ongoing operations of OneCare. HPMS and its software modules are used to collect and receive data.

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.

Healthcare Effectiveness Data and Information Set (HEDIS): A set of standardized performance measures designed to provide purchasers and consumers with relevant information on health plan performance and facilitate the comparison of managed care organizations. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA).

Hierarchical Coding Categories (HCC): A risk-adjusted model developed by CMS to adjust Medicare payments to health care plans for the health expenditure risk of Members.

Homebound: A Member is eligible to be deemed as Homebound if:

1. The Member has been certified by one (1) physician as having a permanent and severe, disabling condition that is not expected to improve;
2. The Member is dependent upon assistance from another individual with at least three (3) of the five (5) activities of daily living for the rest of the Member's life;
3. The Member requires skilled nursing services for the rest of the Member's life and the skilled nursing is more than medication management;
4. An attendant is required to visit the Member on a daily basis to monitor and treat the Member's medical condition or to assist the Member with activities of daily living;
5. The Member requires technological assistance or the assistance of another person to leave the home; and
6. The Member does not regularly work in a paid position full-time or part-time outside the home.

Home Health Agency: A public or private agency or organization that offers home care services including skilled nursing services and at least one other therapeutic service in the residence of the client through physicians, nurses, therapists, social workers, and homemakers whom they recruit and supervise.

Home Health Care: Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, Durable Medical Equipment, medical supplies, and other services.

Home Health services: Medically related services provided to Members in a home setting rather than in a medical facility such as a hospital or a primary health care center.

Hospice: A program of care for beneficiaries who are terminally ill to live comfortably, where the focus is on comfort and not on curing an illness. The hospice is responsible for covering all drugs and biological for the palliation and management of the terminal illness and related conditions.

Hospice Beneficiary: Beneficiary who is eligible for Medicare Part A and has elected hospice care.

Hospital Acquired Conditions (HAC): As defined on Section 5001(c) of Deficit Reduction Act of 2005 defines Hospital Acquired Conditions (HACs) as those conditions that are:

1. High cost or high volume or both;
2. Result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis; and

Could reasonably have been prevented through the application of evidence-based guidelines.

IBNR: IBNR means "incurred but not reported" and refers to an estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.

Immediate Corrective Action Plan (ICAP): The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.

Important Message From Medicare (IM) Notice: A notice given by the hospital to a patient receiving Medicare health care benefits, within two (2) days of being admitted to the hospital, but not sooner than seven (7) days prior to admission, and when the patient is going to be discharged, that explains the patient's rights and tells them how to ask for an expedited review of the discharge decision by the Quality Improvement Organization (QIO).

Incarceration: This term refers to the status of an individual who is confined to a correctional facility, such as a jail or prison. An individual who is incarcerated is considered to be residing outside of the service area for the purposes of Medicare Advantage (MA) plan eligibility, even if the correctional facility is located within the plan service area.

Incurred: The time at which medically necessary services, supplies, or treatment is rendered by a Provider to a Member.

Independent Pharmacy: One (1) or more licensed retail Pharmacies operated under a single business name or multiple business names, or which may be linked under a unique marketing logo or name, but which operate independently of each other as shown by an absence of a uniform set of operating policies and procedures covering all aspects of their operation, and which may or may not be organized under a single ownership and management structure, including franchises.

Independent Review Entity (IRE): An independent entity contracted by CMS to review adverse level 1 appeal decisions made by CalOptima Health. Under Part C, an IRE can review plan dismissals.

Individual Care Plan (ICP): A written plan of care developed after an assessment of a Member's social and health care needs that reflects what services the Member will receive to reach and keep his or her best physical, mental, and social well-being.

Informed Consent: The process by which a treating Provider informs a Member or a Member's Authorized Representative about the procedure, indications, contraindications, significant risks, alternate treatment approaches, and answers questions regarding the procedure prior to the procedure being performed.

Initial Care Plan (iCP): A basic care plan which is created by means of a proprietary algorithm based on a Member's responses to the Health Risk Assessment questions. In the absence of an HRA, the Data iCP is created utilizing all available data such as utilization, claims, encounter and pharmacy. The purpose of the iCP is to provide a baseline for the Health Network to develop an Individual Care Plan for the Member.

Initial Coverage Election/Enrollment Period (ICEP): The Election Period that is three (3) months immediately before an individual's entitlement to both Medicare Part A and Part B.

Inquiry: Any verbal or written request for information to a CalOptima Health or its delegated entities that does not express dissatisfaction or invoke a CalOptima Health's grievance, coverage or appeals process, such as a routine question about a benefit.

Institution: A facility that meets Medicare's definition of a skilled nursing facility, such as a nursing home and any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 1902(q)(1)(B) of the Social Security Act. Institution does not include assisted or adult living facilities, or residential homes.

Integrated Appeal:
(CMS) Any of the procedures that deal with, or result from, adverse integrated organization determinations by CalOptima Health on the health care services the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services such that a delay would adversely affect the health of the Member, or on any amounts the Member must pay for a service.
(DHCS) The procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service. See 42 CFR § 422.561. Integrated appeals do not include appeals related to Part D benefits.

Integrated Grievance: A dispute or complaint that would be defined and covered, for Grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or § 438.400 through 438.416 of this chapter. Integrated Grievances do not include Appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated Grievance made by an enrollee in an applicable integrated plan is subject to the integrated Grievance procedures in §§ 422.629 and 422.630. Integrated Grievances do not include Grievances related to Part D benefits.

Integrated Organization Determination: Means an organization determination that would otherwise be defined and covered, for a non-Applicable Integrated Plan, as an organization determination under 42 CFR section 422.566, an adverse benefit determination under 42 CFR section 438.400(b), or an action under 42 CFR 431.201. An Integrated Organization Determination is made by an Applicable Integrated Plan and is subject to the Integrated Organization Determination procedures in 42 CFR sections 422.629, 422.631, and 422.634.

Integrated Reconsideration: A reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under § 422.580 and appeal under § 438.400(b) of this chapter. An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in §§ 422.629 and 422.632 through 422.634. Integrated reconsiderations do not include redeterminations related to Part D benefits. Subject to the guidance in this Addendum, wherever the Part C & D Guidance refers to a "Reconsideration," the statements and guidance apply equally to integrated reconsiderations for applicable integrated plans.

Interdisciplinary Care Team (ICT): A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).

Intermediary: An entity that has a contract with the Centers for Medicare & Medicaid Services (CMS) to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis, or under the prospective payment system for hospitals, and to perform other related functions.

Intermediate Care Facility (ICF): A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.

International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) Codes: 3- to 5-digit codes used to describe the clinical reason for a patient's treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations. ICD-9-CM codes are used for inpatient discharges before the implementation date of ICD-10, and for outpatient and physician services before that date.

International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) Codes: 3- to 7-digit codes used to describe the clinical reason for a patient's treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations. ICD-10-CM codes are used for inpatient discharges on and after the implementation date of ICD-10, and for outpatient and physician services on and after that date.

Internet Pharmacy: A licensed Pharmacy that accepts Prescription requests and conducts the majority of its Prescription business through an Internet web site and which distributes the Prescription medications and supplies for consumer use through the United States (U.S.) mail or by use of other common carrier services.

Inter-Rater Reliability: An assessment tool that measure the degree of reliability of different licensed staff when utilizing criteria for authorizing or denying Covered Services.

Intrusion: The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health, or its Business Associates.

Investigational Services: Drugs, equipment, procedures, or services for which laboratory and animal studies have been completed and for which human studies are in progress but testing is not complete (Phase III clinical trials are not yet completed and published), the efficacy and safety of such services in human subjects are not yet established, and the service is not generally accepted by the medical community in the United States or in widespread general medical usage in the United States.

Key Events: Key Event alerts include, but are not limited to:

1. Hospital or skilled nursing facility (SNF) admission;
2. Emergency Department (ED) visit;
3. New behavioral health referral;
4. Alteration in mental or functional status;
5. Change in care setting;
6. Change in medication;
7. Entry into Medication Therapy Management (MTM);
8. Change in Managed Long Term Services and Supports (MLTSS) level;
9. Multiple falls;
10. Authorization request for out of area provider; and
11. Unsafe home environment.

Key Personnel: Health Network staff, including but not limited to, an officer, executive, administrator, director, or equivalent who has or can be assigned signature authority on behalf of the legal entity; who maintains a fiduciary duty on behalf of the legal entity; and/or who is responsible for plan administration, quality improvement, utilization management, customer service and/or provider relation.

Key Points of Contact: Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.

Legal Representative/Authorized Representative: 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.)

Limited Data Set: Protected Health Information (PHI) that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.

Lock-In Requirement: The requirement for a Member to access services through designated Providers within OneCare with the exception of Emergency Services and Urgent Care.

Long Term Care (LTC): A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following:

1. Community-Based Adult Services (CBAS);
2. Multipurpose Senior Services Program (MSSP) services;
3. Skilled Nursing Facility services and subacute care services; and
4. In-Home Supportive Services (IHSS).

Loss: Eligible Expenses that are actually incurred on behalf of a Member during the Reinsurance Contract Year and paid by the Health Network during the contract or six (6) months immediately following the Reinsurance Contract Year, for medical treatment and services provided to a Member in accordance with the Health Network Service Agreement.

Low-Income Cost-Sharing Subsidy (LICS): Extra help for eligible Medicare beneficiaries who have limited income and resources to pay for their Medicare benefits. LICS is subject to eligibility requirements as set forth by CMS guidance and CalOptima Health policy.

Low-Income Subsidy (LIS): Provides extra help for people with Medicare Part D who have limited income and resources by helping to pay their Medicare Prescription Drug Benefit costs (plan monthly premiums, co-payments, and the annual deductible).

Mail Order Pharmacy: A licensed Pharmacy that accepts Prescription requests by U.S. mail or electronic facsimile and that conducts the majority of its Prescription business by U.S. mail, and that distributes the majority of its dispensed Prescription medications for consumer use by U.S. mail or by use of other common carrier services.

Management Services Organization (MSO): A healthcare entity providing management and administrative support service on behalf of the delegated medical group.

Market Withdrawals: A manufacturer's removal or correction of a distributed product that involves a minor violation which would not be subject to legal action by the Food and Drug Administration (FDA).

Marketing: Activities and use of materials that are conducted by CalOptima Health with the intent to draw a beneficiary's attention to CalOptima Health and to influence a beneficiary's decision- making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, marketing contains information about CalOptima Health's benefit structure, cost sharing, measuring or ranking standards.

Marketing Activity: Any product or activity intended to encourage retention of or an increase in Contracted Membership or any occasion during which Marketing Materials are presented to Members or persons who may become Members through verbal exchanges or the distribution of Marketing Materials. Marketing Activities may include but are not limited to health fairs, workshops on health promotion, after school programs, raffles, informational sessions hosted by Providers, community-based social gatherings, and posting of Marketing Materials on the internet.

Marketing Appointments: Marketing Appointments are individual appointments designed to steer or, attempt to steer, potential enrollees toward a plan or limited number of plans. All individual appointments between an agent and a beneficiary are considered marketing/sales appointments regardless of the content discussed.

Marketing Materials: Materials defined in the Centers for Medicare & Medicaid Services (CMS) marketing guidelines set forth in the Medicare Managed Care Manual as any informative materials targeted to Medicare beneficiaries that:

1. Promotes OneCare or communicate or explain OneCare;
2. Informs Medicare beneficiaries that they may enroll, or remain enrolled in, OneCare;
3. Explains the benefits of enrollment in OneCare or rules that apply to enrollees; and
4. Explains how Medicare services are covered under OneCare including conditions that apply to such coverage.

Marketing materials include notification forms and letters used to enroll, disenroll, and communicate with a Member, any information or product that is designed to encourage retention of or an increase in Contracted Membership, and is produced in a variety of print, broadcast, and direct marketing media that include, but are not limited to: radio, television, billboards, newspapers, the internet, leaflets, informative materials (ex. Summary of Benefits, Approved Formulary), videos, advertisements, letters, posters, and items of nominal value.

Marketing/Sales Event: Market/sales Events are events designed to steer, or attempt to steer, potential enrollees toward a plan or a limited set of plans. At Marketing/sales Events, the Plan/Part D Sponsor may promote specific benefits/premiums and/or services offered by the plan. Plans/Part D Sponsors may conduct a formal event where a presentation is provided to Medicare beneficiaries or an informal event where Plans/Part D Sponsors are only distributing health plan brochures and pre-enrollment materials. Plans/Part D Sponsors may also accept enrollment forms and perform enrollment at marketing/sales event.

Master Trainer: A registered nurse (RN) or physician who has completed site review training and has received certification as a Master Trainer from the Medical Managed Care Division of the Department of Health Care Services (DHCS).

McKesson InterQual© Criteria: Proprietary Criteria established by McKesson Corporation that are continually reviewed, updated, and released annually. McKesson Corporation utilizes a national pool of multi-specialty consultants to review the McKesson InterQual© Criteria and incorporates extensive end-user feedback into the development cycle.

Medical Board of California (MBC): The state agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Medi-Cal Managed Care Plan (MCP): A managed care health plan that contracts with DHCS for provision or arrangement of Medi-Cal benefits and services. For the purposes of the State Medicaid Agency Contract, this includes Subcontracted Delegate Health Plans. A Subcontracted Delegate Health Plan is a health care service plan that is a subcontractor of a MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Dual Eligible Beneficiary that are covered under the applicable comprehensive risk contract of the MCP.

Medi-Cal Fee-For-Service (FFS): means the Med-Cal delivery system in which providers submit claims to and receive payments from DHCS for services covered under Medi-Cal and rendered to Medi-Cal recipients.

Medi-Cal Services: All services covered by the Medi-Cal program as identified in Exhibit H, of the Contract between DHCS and CalOptima Health.

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.

Medical Record Review (MMR): A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.

Medically-Accepted Indication: The use of a covered Part D drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act. The compendia are:

1. American Hospital Formulary Service Drug Information,
2. DRUGDEX Information System, and
3. United States Pharmacopeia-Drug Information (or its successor publications).

Medically Necessary: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medically Necessary or Medical Necessity: 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.

Medicare Advantage Disenrollment Period: MA plan enrollees have an annual opportunity to prospectively disenroll from any MA plan and return to Original Medicare between January 1 and February 14 of every year.

Medicare Part B Vaccines: Medicare Part B covered vaccines include Hepatitis B, Influenza virus, Pneumococcal, and other vaccines directly related to the treatment of an injury or direct exposure to a disease or condition.

Medicare Part D Vaccines: Medicare Part D vaccines are those not covered by Part B and used as reasonable and necessary to prevent illness.

Medicare Secondary Payer (MSP): The term generally used when the Medicare program does not have primary payment responsibility.

Medicare Secondary Payer (MSP) Vendor: Third party vendors contracted to perform administrative functions with regards to the identification and recovery of monies owed to OneCare for recoupment of conditional payments. These administrative duties include, but are not limited to, the pursuit of repayments for third party liabilities and other health care coverage.

Medication Over-utilization: Any medication when used:

1. In excessive dose, including duplicate therapy;
2. For an excessive duration;
3. Without adequate monitoring;
4. Without adequate indications for its use;
5. In the presence of adverse consequences indicating a reduction in dose, or a discontinuation of the medication; or
6. Any combinations of the reasons above.

Medicare Non-Participating Provider: A doctor or supplier who does not accept assignment on all Medicare claims. May accept assignment on a case-by-case basis and indicates this by checking affirmatively in field 27 on the CMS 5010 claims form. In these instances, no balance billing of enrollees by the provider is permitted.

Medicare Participating Provider: A provider that signs an agreement with Medicare to always accept assignment. The MACs post lists of Medicare participating providers. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors or suppliers may bill you only for Medicare deductible and/or coinsurance amounts. (See Assignment.)

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.

Medication Under-utilization: Insufficient medication dosing or omission of an indicated drug from a Member's medication regimen.

Member: A beneficiary enrolled in the CalOptima Health OneCare program.

Member (Global): A beneficiary enrolled in a CalOptima Health program.

Member Advisory Committee (MAC): A committee comprised of Members representing a cross-section of the population served by CalOptima Health and community advocates established by CalOptima Health to advise its Board of Directors on issues impacting Members.

Mental Health Provider: A person or entity that is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide Mental Health Services and that meets the standards for participation in the Medicare program. Mental Health Providers include clinics, hospital outpatient departments, certified residential treatment facilities, Skilled Nursing Facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, and registered nurses authorized to provide Mental Health Services.

Mental Health Services: Covered Services that include:

1. Rehabilitative services, including medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and health facility psychiatric services;
2. Psychiatric inpatient hospital services that are designed to both reduce or control a Member's psychotic or neurotic symptoms that necessitated hospitalization and improve the Member's level of functioning;
3. Targeted case management;
4. Psychiatrist services; and
5. Psychologist services.

Merit-based Incentive Payment System (MIPS): Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program.

Mid-Level Practitioner: A Registered Nurse Practitioner (RNP), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Optometrist, Acupuncturist, Licensed Clinical Social Worker (LCSW), or Chiropractor.

Minimum Necessary: The principle that a covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request for Treatment, Payment or Health Care Operations.

Model Document: Model documents are materials for which CMS has provided model language which, when used without modification, qualifies for a 10-day review or for submission through the File & Use process.

Model of Care (MOC): A care management process which supports the unique health care needs of a population. The MOC provide the needed infrastructure to promote quality care management and care coordination processes.

Monitoring: An on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.

National Committee of 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.

Network Pharmacy: A licensed pharmacy that is under contract with a Part D sponsor to provide covered Part D drugs at negotiated prices to its Part D plan enrollees.

New Technology: An advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Members.

Non-clean Claim: A claim for Covered Services that lacks required documentation such as medical records or authorization numbers.

Non-Contracted Provider (NCP): A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.

Non-Emergency Medical Transportation: 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.

Notice of Medicare Non-Coverage (NOMNC): A document that informs Members when their Medicare covered service(s) for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) is ending and how to request an expedited determination from their Quality Improvement Organization (QIO).

Notice of Privacy Practices (NPP): Notice provided to a Member that describes CalOptima Health's practices in the use and disclosure of Protected Health Information, Member rights, and CalOptima Health legal duties with respect to Protected Health Information.

Open Enrollment/Election Period (OEP): An annual Election Period, as determined by the Centers for Medicare & Medicaid Services (CMS) during which time an eligible beneficiary may elect a Medicare Advantage plan or Original Medicare.

Organization Determination: Any determination made by CalOptima Health, or its delegated entity with respect the following:

1. Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
2. Payment for any other health services furnished by a Provider that the Member believes:
a. Are covered under Medicare; or
b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health.
3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by CalOptima Health;
4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or
5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.

Organizational Providers: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.

Original Medicare: The traditional Medicare Fee-for-Service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Other Health Coverage (OHC): Evidence of health coverage other than OneCare including, but not necessarily limited to:

1. The CalOptima Health Medi-Cal program;
2. Group health plans;
3. Federal Employee Health Benefits Program (FEHB);
4. Military coverage, including TRICARE;
5. Worker's Compensation;
6. Personal Injury Liability compensation;
7. Black Lung federal coverage;
8. Indian Health Service;
9. Federally qualified health centers (FQHC);
10. Rural health centers (RHC); and/or
11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.

Out-of-Area: Outside of the Service Area.

Out-of-Network: Outside of the selected Health Network's participating provider network within the Service Area.

Over Utilization: Unnecessary health care provided with a higher volume or cost than is appropriate in delivering quality health care services.

Pap Smear: A test for cancer of the cervix.

Partial Hospitalization: Mental Health Services that may prevent the need for inpatient psychiatric care. Partial Hospitalization may include individual and group therapy, occupational therapy, drugs and biologicals that cannot be self-administered, family counseling, and diagnostic services.

Participating Pharmacy: Any Pharmacy that is credentialed by, and contracted with, the Pharmacy Benefit Manager (PBM) to provide Pharmaceutical Services to Members.

Participating Pharmacy Network: The Pharmacies that are authorized by the PBM to provide Pharmaceutical Services to Members, as set forth in CalOptima Health's list of Participating Pharmacies.

Party in Interest: Includes the following:

1. Any director, officer, partner, or employee responsible for management or administration of a Medicare Advantage organization;
2. Any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the organization's equity; or the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than five percent (5%) of the organization;
3. In the case of a Medicare Advantage organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
4. Any entity in which a person described in paragraph (1), (2), or (3) of this definition:
   a. Is an officer, director, or partner; or
   b. Has the kind of interest described in paragraphs (1), (2), or (3) of this definition.
5. Any person that directly or indirectly controls, is controlled by, or is under common control with, the Medicare Advantage organization; or
6. Any spouse, child, or parent of an individual described in paragraph (1), (2), or (3) of this definition.

Payment: Has the meaning in Title 42 of the Code of Federal Regulations, Section 164.501, including: activities carried out by CalOptima Health including:

1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities;
2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and
3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Payment Appeal: An Appeal involving an Organization Determination regarding payment for services rendered to a Member.

Peer Review: The concurrent or retrospective review by practicing physicians or other health professionals of the quality and efficiency of patient care practices or services ordered or performed by other physicians or other health professionals.

Peer Review Body: The group of physicians responsible for reviewing, evaluating, and making recommendations concerning the qualifications of Practitioners for participation in OneCare.

Performance Review Guide: CalOptima Health's performance assessment tool to review Contracted Provider performance and compliance related to specific statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to OneCare. The Performance Review Guide lists the areas, standards, provisions, and elements of review and includes a summary of the review, compliance scoring, comments, and recommendations or directives for correction.

Performance Measurement: The regular collection of data to assess whether the correct processes are being performed and desired results are being achieved.

Performance Measures: Development, application and use of performance measures to assess achievement of standards.

Personal Care Coordinator (PCC): A para-professional whose function is to promote coordination of care by bridging the gap between OneCare and the Health Network. The role of the PCC is to facilitate communication between the Member, OneCare, the Health Network, the Primary Care Provider (PCP) and the Interdisciplinary Care Team (ICT). The PCC assists the Member to navigate the healthcare delivery system and facilitates access to care and services.

Personal Representative: Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.

Personally Identifiable Information (PII): Any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Pharmaceutical Services: Covered drugs and related professional services provided to a Member pursuant to applicable state and federal laws, CalOptima Health's Pharmacy Services Program Manual, and the standard of practice of the pharmacy profession of the state in which the Pharmacy is located.

Pharmacist: A person to whom the State Board of Pharmacy has issued a license, authorizing the person to practice pharmacy.

Pharmacist-In-Charge (PIC): The licensed Pharmacist designated by each Pharmacy in accordance with Title 16, California Code of Regulations, Section 1709.1, who is legally responsible for that Pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

Pharmacy: An area, place, or premise licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed.

Pharmacy & Therapeutics (P&T) Committee: A committee, the majority of whose members shall consist of individuals who are practicing physicians or practicing pharmacists (or both), that is charged with developing and reviewing a formulary. Such committee shall include at least one practicing physician and at least one (1) practicing pharmacist, each of whom is independent and free of conflict with respect to the Sponsor and at least one practicing physician and at least one practicing pharmacist who have expertise in the care of elderly or disabled persons. (*See* Title 42 C.F.R. § 423.120(b)(1)).

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.

Pharmacy Benefit Manager (PBM) Services Agreement: The written agreement between a PBM and CalOptima Health regarding the delivery and maintenance of the Participating Pharmacy Network.

Pharmacy Technician: A person who assists a Pharmacist in the performance of Pharmacy-related duties, to whom the State Board of Pharmacy has issued a certificate of registration to act as a Pharmacy Technician.

Physical Accessibility Review (PAR): A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.

Polypharmacy: The inappropriate, excessive use of medications that increases the risk for drug interactions and adverse drug reactions.

Population Needs Assessment (PNA): An evaluation which identifies member health status and behaviors, member health education and C&L needs, health disparities, and gaps in services related to these issues.

Post-Enrollment Marketing Materials: Post-enrollment Marketing Material is a subset of marketing materials used by a Plan/Part D Sponsor to convey benefits or operational information to current enrollees.

Post Service Review: Any review for care or services where that care or service has already been received (i.e., retrospective review).

Post-Stabilization Care Services: 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.

Potential At-Risk Beneficiary (PARB): A Part D eligible individual: (1) who is identified using clinical guidelines for potential overutilization of frequently abused drugs such as Opioid medications under CalOptima Health's Drug Management Program; or (2) with respect to whom CalOptima Health receives a notice upon the Member's enrollment that the Member was identified as a potential at-risk beneficiary under the Part D plan in which the Member was most recently enrolled and such identification had not been terminated upon disenrollment.

Potential Quality Issue (PQI): Any issue whereby a Member's quality of care may have been compromised. A PQI requires further investigation to determine whether an actual quality issue or opportunity for improvement exists.

Practitioner: A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services.

Preclusion List: CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Pre-Enrollment Marketing Materials: Pre-enrollment Marketing Material is a subset of marketing materials used prior to enrollment. Pre-enrollment materials may contain plan rules and/or benefit information.

Preferred Drug Product: A medication on the Formulary that provides therapeutic effectiveness at the most reasonable cost when more than one therapeutically equivalent product is available on the Formulary approved by the Pharmacy & Therapeutics (P&T) Committee.

Prenatal Care Provider: A Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Nurse Practitioner, Physician Assistant (PA), or Certified Nurse -Midwife who provides prenatal care to a Member under the supervision of a licensed physician.

Prescriber (Pharmacy): A healthcare professional who is authorized under State law or other applicable law to write prescriptions.

Prescriber Supporting Statement (Pharmacy): A statement of medical justification consistent with the requirements set forth in Title 42 of the Code of Federal Regulations, Section 423.578(b)(5). An oral or written supporting statement, provided by the Prescriber, that the requested prescription drug is Medically Necessary to treat the Member's disease or medical condition because—

1. All of the Covered Part D Drugs on any tier of the Formulary for treatment for the same condition would not be as effective for the Member as the non-Formulary drug, would have adverse effects for the Member, or both;
2. The prescription drug alternative(s) listed on the Formulary or required to be used in accordance with Step Therapy requirements—
    a. Has been ineffective in the treatment of the Member's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence and the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
    b. Has caused or based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the Member; or
3. The number of doses that is available under a dose restriction for the prescription drug has been ineffective in the treatment of the Member's disease or medical condition or, based on both sound clinical evidence and

medical and scientific evidence and the known relevant physical or mental characteristics of the Member and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

Prescribing Provider: The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.

Prescription: An oral, written, or electronic transmission order that meets the requirements of the California Business and Professions Code, Chapter 9, Division 2, Article 2, Section 4040.

Pre-Service Review: Review of any case or service that requires approval by OneCare or a Health Network, in whole or in part, in advance of the Member obtaining medical care or services. Pre-authorization and pre-certification are pre-service decisions.

Primary Care Practitioner/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.

Primary Payer: Any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a group health plan or large group health plan, a worker's compensation law or plan, an automobile or liability insurance policy or plan, including a self-insured plan), or no-fault insurance. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

Primary Source Verification (PSV): The process by which a Health Network or sub-delegated entity verifies Credentialing and Recredentialing information from the organization that originally conferred or issued the Credentialing element to the Practitioner.

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.

Protected Health Information (PHI): Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

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.

Provider Advisory Committee (PAC): A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

Provider Preventable Conditions: A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition," as defined in 42 CFR 447.26(b).

Prudent Layperson: A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.

Psychotherapy Notes: Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. Notes recorded (in any medium) by a health care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the Member's medical record. Psychotherapy Notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the Treatment plan, symptoms, prognosis, and progress to date.

Public Benefit Program: Programs including the Medi-Cal program, social security disability insurance benefits, and Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP).

Purchase Records: All of Participating Pharmacy's purchase invoices, periodic statements, and credit or return memos from all sources, and documentation of the Participating Pharmacy's payments for all drug or medical supply acquisitions, including business bank statements, copies of checks, and any other documents required by the PBM or CalOptima Health.

Qualified Family Planning Practitioner: A qualified provider licensed to furnish family planning services within their scope of practice within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish Family Planning Services to a Member as specified in title 22, Code of California Regulations, Section 51200.

Qualified Health Educator: A qualified health educator is defined as a health educator with one (1) of the following qualifications:

1. Master of Public Health (MPH) degree with a health education or health promotion emphasis;
2. Master's degree in community health with a specialization in health education or health promotion; or
3. MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc.

Quality Assessment and Performance Improvement (QAPI): QAPI projects address areas identified as health care priorities for Medicare beneficiaries. Projects focus both on clinical and non-clinical priorities aimed at reducing morbidity and mortality rates in the Medicare population, as well as improving the quality of services provided by OneCare.

Quality Improvement Health Equity Committee (QIHEC): The CalOptima Health committee responsible for the Quality Improvement (QI) process.

Quality Improvement Organization (QIO): An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.

Quality Improvement Project: A component of a comprehensive quality improvement program that addresses the quality of clinical care as well as the quality of health services delivery. A Quality Improvement Project is an initiative by the organization to measure its own performance in major focus areas of clinical and non-clinical care.

Quality Improvement Workgroup: At the direction of the Quality Improvement Committee, the Quality Improvement Workgroup ensures that Quality Improvement activities are consistent with CalOptima Health's strategic goals and priorities.

Quality Indicators: Measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcomes of care delivered in that clinical area.

Quality Initiatives: Initiatives that encompasses quality improvements projects and other activities that addresses the quality of care and health services delivery of members. Performance measurements are utilized to assess achievement of standards in focus areas of clinical and non-clinical.

Quality of Access/Availability: Either of the following:

1. The extent to which a Member may access available services at the time they are needed. Such services refer to telephone access, and ease of scheduling appointments for both Primary Care Physicians and specialists, as well as any available services offered in the Evidence of Coverage; or
2. The extent to which OneCare geographically distributes Practitioners of the appropriate type and number to meet the needs of its membership.

Quality of Care (QOC): The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality of Care Grievance: A grievance related to whether the quality of covered services provided by CalOptima Health or Provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.

Quality of Service (QOS): Service issue resulting in inconvenience or dissatisfaction to Member.

Readiness Assessment: An assessment conducted by a Review Team prior to the effective date of a Contracted Provider's Contract with CalOptima Health of a Contracted Provider's compliance with all or a specified number of operational functional areas as determined by CalOptima Health.

Reason Codes: The alpha/numeric codes used to identify each issue within a Member's Appeal or Grievance.

Reasonably Relevant Information: Minimum amount of itemized, accurate, and material information generated by, or in the possession of, the Provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the

nature, cost, if applicable, and extent of OneCare's liability, if any, and to comply with any governmental information requirements.

Reconsideration: Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by CalOptima Health, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, CalOptima Health or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which CalOptima Health reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.

Records (Pharmacy): All physical and electronic records of drug and medical devise acquisition from and disposition to all persons and entities including, but not limited to drug wholesalers, drug manufacturers and distributors, other Pharmacies and Members, and any other document related to the terms of the PPA. Such Records include but are not limited to license and credentialing records, claims transaction records, Purchase Records, Prescriptions (including all physical and electronic notations related to every Prescription), all Member signature logs, records of payments for drug and device acquisitions, and remittance advice records from the PBM.

Recredentialing: The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in OneCare.

Redetermination: First level in the Part D appeal process in which CalOptima Health reviews an adverse Part D coverage determination, including the findings upon which the decision was based and any other evidence submitted or obtained.

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.

Reinsurance Contract Year: The period beginning and ending on the dates shown in the Schedule of Coverage, both days inclusive, 12:01 a.m. Pacific Standard Time.

Related Entity: Any entity that is related to the Medicare Advantage organization by common ownership or control and:

1. Performs some of the Medicare Advantage organization's management functions under contract or delegation;
2. Furnishes services to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.

Relevant Portion: Those records regarding services rendered to a patient during the time period beginning with the date of the patient's initial application for public benefits up to and including the date that a final determination is made by the Public Benefit Program (PBP) with which the patient's application is pending.

Reopening: A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

Reporting Grid: A matrix of reports required by CalOptima Health, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats.

Report Template: A blank form of each report also including instructions and file layout and/or data dictionary.

Representative: Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D §423.560 *defines "representative" as* an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, *unless otherwise provided in the applicable law,* the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.

Required by Law: Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.

Research: Systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Retail Pharmacy: A Pharmacy open for business to the general public, excluding Mail Order Pharmacies and Internet Pharmacies.

Retaliation: Includes, but not limited to, coercion, threats, intimidation, discrimination, and other forms of retaliatory action against individuals.

Retrospective Drug Utilization Review (RDUR): A retrospective, periodic review of claims data and other records through computerized drug claims processing and information retrieval systems.

Retrospective Recoveries (Pharmacy): When payment has been made by a Part D plan sponsor for a prescription drug under a Member's Medicare Part D plan and is later identified to be the financial responsibility of another payer, such as a Hospice Provider under Medicare Part A, the process to collect payment from the responsible payer is retrospective recovery.

Reward Item: The item furnished to a qualifying individual who performs a target activity as specified by CalOptima Health in the reward program.

Reward and Incentive (R&I) Program: This is a program offered by CalOptima Health to qualifying individuals to voluntarily perform specified target activities in exchange for reward items.

Review Team: The group of CalOptima Health employees or agents designated to conduct a performance assessment of a contracted entity. The Review Team is comprised of representatives of functional departments or an independent audit vendor as determined by the Compliance Department and led by CalOptima Health's Compliance Director.

Sales and Marketing Vendor: A vendor contracted with CalOptima Health to provide sales and marketing functions for OneCare.

Sales Person: An individual who markets and/or sells products for a single plan sponsor or numerous plan sponsors. It includes employees, brokers, agents, and all other individuals, entities, and downstream contractors that may be utilized to market and/or sell on behalf of a plan sponsor.

Sanction: An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

Screening: The assessment of a Member's health concerns and symptoms via communication with a qualified health professional acting within his or her scope of practice and who is trained to screen a Member who may need care, for the purpose of determining the urgency of the Member's need for care.

Scripts: Talking Points are standardized text. Informational Talking Points are designed to respond to beneficiary questions and requests and provide objective information about a plan or the Medicare program. Sales and enrollment Talking Points are intended to steer a beneficiary towards a plan or limited number of plans, or to enroll a beneficiary into a plan.

Seating and Positioning Components (SPC): Seat, back and positioning equipment mounted to the Wheelchair base.

Seating Clinic: A CalOptima Health contracted utilization management evaluation by a multidisciplinary team led by a principal therapist to evaluate a Member's needs for a Custom Seating System, recommend the most appropriate Custom Seating System, fit the Custom Seating System, and Report UM activity.

Second Opinion: A consult visit to an Appropriately Qualified Health Care Professional in order for a Member or Contracted Provider who is treating the Member, to receive the additional information for the Member to make an informed decision regarding care and treatment.

Security Incident: Has the meaning in 45 Code of Federal Regulations Section 164.304.
The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Self-Referral: Any service or specialty appointment that a Member may schedule and obtain without having to seek a Provider's request for Direct Referral Authorization or Pre-service Review (i.e., women's health services and covered immunizations).

Serious Chronic Condition: A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that either:

1. Persists without full cure or worsens over an extended period, or
2. Requires ongoing treatment to maintain remission or to prevent deterioration.

Service Appeal: An Appeal involving an Organization Determination regarding provision of services prior to a Member's receipt of such services.

Service Area: The county or counties that CalOptima Health is approved to operate in under the terms of the 2024 D-SNP Contract. A Service Area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this D- SNP Contract

Significant Business Transaction: Any business transaction or series of transactions of the kind specified in the definition of Business Transaction that, during any OneCare fiscal year, have a total value that exceeds twenty-five-thousand dollars ($25,000) or five percent (5%) of CalOptima Health's total operating expenses, whichever is less.

Skilled Nursing Facility (SNF): A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Solucient Length of Stay Norms: Length of stay data compiled by Solucient from a comprehensive all-payer database that is continually updated and contains over eleven (11) million discharges. Solucient is owned by VS&A Communications Partners III, LP.

Special Election/Enrollment Periods (SEP): Election Period provided to individuals in situations where:

1. The individual has made a change in residence outside of the service area or continuation area or has experienced another change in circumstances as determined by Centers for Medicare & Medicaid Services (CMS) (other than termination for non-payment of premiums or disruptive behavior) that causes the individual to no longer be eligible to elect the Medicare Advantage plan;
2. CMS or the organization has terminated the Medicare Advantage organization's contract for the Medicare Advantage plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan or the impending discontinuation of the plan in the area in which the individual resides;
   The individual demonstrates that the Medicare Advantage organization offering the Medicare Advantage plan substantially violated a material provision of its contract under Medicare Advantage in relation to the individual, or the Medicare Advantage organization (or its agent) materially misrepresented the plan when marketing the plan;
3. The individual is entitled to Medicare Part A and Part B and receives any type of assistance from Medi-Cal; or
4. The individual meets such other exceptional conditions as CMS may provide.

Special Needs Plan: Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including; institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.

Special Needs Status: Eligibility entitlement to Medi-Cal services.

Specialty Care Center: A center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

Standardized Language: Standardized Language is language developed by CMS or another Federal agency that is mandatory for use by the Plan/Part D sponsor and cannot be modified except as noted by CMS (e.g., ANOC, EOC, Plan Ratings).

Standards of Care: A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance conforming to an established rule that is approved and monitored for compliance by an authoritative agency or professional.

Standing Referral: A referral to a specialist for more than one (1) visit, as indicated in an Active Treatment Plan, if any, without the Provider having to provide a specific referral for each visit.

State: State of California

Stem Cell Transplant: A process which includes mobilization, harvesting, and transplant of peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant.

Sterilization: Surgical procedure that results in infertility.

Sub-Contracting: A written agreement entered into by CalOptima Health with any of the following:

1. A provider of health care services who agrees to furnish Covered Services to Members; or
2. Any other organization or person(s) who agree(s) to perform any administrative function or service for CalOptima Health specifically related to fulfilling CalOptima Health's obligations to CMS.

Sub-Delegate: An entity that has entered into a written agreement with a Health Network or other delegated Provider to perform certain operational functions that would otherwise be required to be performed by CalOptima Health, the Health Network or other delegated Provider, in order to meet contractual and/or regulatory obligations. Examples of a Sub-Delegate may include, but are not limited to, a management services organization (MSO) or a credentials verification organization (CVO).

Subcontracted Delegate Health Plan: A health care service plan that is a subcontractor of a Medi-Cal managed care plan that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a dual eligible beneficiary that are covered under the applicable comprehensive risk contract of the Medi-Cal managed care plan.

Sub-delegation: The process by which a Health Network expressly grants, by a formal agreement, to a sub-delegated entity the authority to carry out a function that would otherwise be required to be performed by the Health Network in order to meet its obligations under the Health Network Service Agreement.

Supplemental Benefits: All of the following under Medicare Advantage definitions: Initial and Expansion Primarily Health Related Supplemental Benefits, Special Supplemental Benefits for the Chronically Ill, and Value Based-Insurance Design Model benefits.

Talking Points: Talking Points are standardized text. Informational Talking Points are designed to respond to beneficiary questions and requests and provide objective information about a plan or the Medicare program. Sales and enrollment Talking Points are intended to steer a beneficiary towards a plan or limited number of plans, or to enroll a beneficiary into a plan.

Target Activity: A target activity in an R&I program must meet all of the following:

1. Directly involve the qualifying individual and performance by the qualifying individual.
2. Be specified, in detail, as to the level of completion needed in order to qualify for the reward item.
3. Be health-related by doing at least one of the following:
    a. Promoting improved health.
    b. Preventing injuries and illness,
    c. Promoting the efficient use of health care resources.
4. Uniformly offer any qualifying individual the opportunity to participate in the target activity.
5. Be provided with accommodations consistent with the goal of the target activity to otherwise qualifying individuals who are unable to perform the target activity in a manner that satisfies the intended goal of the target activity.

Target Activity (Quality Analytics): The activity for which the reward is provided to the qualifying individual by CalOptima Health.

Targeted Beneficiary: A CalOptima Health Member who meets the eligibility criteria of the MTM program, which includes having at least three (3) qualifying core chronic diseases, is taking eight (8) or more Part D medications per quarter, and one who is likely to incur annual costs for Covered Part D Drugs greater than or equal to the MTM annual cost threshold as further identified in this Policy.

Targeted Medication Review (TMR): A review focused on specific or potential medication-related problems. The identified problem is communicated directly to the Member's prescriber.

Technology Assessment: A multidisciplinary field of policy analysis studying the medical, social, ethical, and economic implications of the development, diffusion, and use of new and existing technologies.

Terminal Illness: An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

Tertiary Care: Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.

Third Party Administrator (TPA): An individual or entity that has a written agreement with CalOptima Health to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.

Third Party Administrator (TPA) Agreement: A contract between a TPA and a Provider for the provision of Covered Services to Members.

Third Party Marketing Organization (TPMO): Means organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of CalOptima Health or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under 42 CFR § 422.2, but may also be entities that are not FDRs but provide services to CalOptima Health or a CalOptima Health FDR.

Threshold Language: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.

Trainer: A registered nurse (RN) or physician who has completed site review training and has been certified as a reviewer or Trainer by the Master Trainer. The Trainer may assist the Master Trainer in providing training and supervision of staff responsible for conducting Full Scope Site Reviews.

Transition of Care: The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Transition Period/Timeframe: A Member's Transition Period/Timeframe begins with the date of each enrollment. Even if a beneficiary leaves CalOptima Health and then re-enrolls the following month, the Transition Period/Timeframe shall begin with each enrollment for ninety (90) days.

Transplant: A non-experimental procedure for Solid Organ or Stem Cell Transplant.

Treatment: Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.

True Out-of-Pocket (TrOOP) Cost: True Out-of-Pocket (TrOOP) Costs are the payments that count toward a Part D beneficiaries' Medicare drug plan out-of-pocket threshold. TrOOP Costs determine when a beneficiaries' catastrophic coverage will begin.

True Out-Of-Pocket (TrOOP) Expenditures: A Member's out-of-pocket expenditures that will count toward the TrOOP Threshold.

True Out-Of-Pocket (TrOOP) Threshold: The annual amount a Member must spend on Covered Part D Drugs to reach the catastrophic cap.

1. In 2006, the TrOOP Threshold is equal to three-thousand-six hundred dollars ($3,600).
2. In subsequent years, the TrOOP Threshold is equal to the amount for the previous year increased by an annual percentage as specified in the Medicare Modernization Act, Section 1860D-(2)(b)(6).

Under Utilization: A condition wherein the optimal healthcare resources are not being delivered in the appropriate volume to provide quality health care services.

Unprocessable Claim: Any claim that:

1. Is incomplete or is missing required information; or
2. Contains complete and necessary information, however, the information provided is invalid.

Unsecured PHI/PI: Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.

Urgent Care: Services furnished to a Member who requires services to be furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition.

Urgently Needed Services: Non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

Use: Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Use of PHI: Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Utilization Management (UM) Appeal: A request for Reconsideration of a UM decision to deny, terminate, modify, or defer a request for services based on medical necessity.

Utilization Management (UM) Committee: The CalOptima Health committee that provides coordination and oversight of delegated and non-delegated Utilization Management functions to ensure consistency in evaluation and delegation oversight.

Utilization Management (UM) Program: A written document evaluated and revised on an annual basis that describes the Utilization Management policies, procedures, processes, and programs that are implemented organizationally to attain goals set forth by the health plan to meet health plan, state, federal, and accrediting agency requirements.

Utilization Management (UM) Standards: Conforming to an established rule that is approved and monitored for compliance by an authoritative agency or professional.

Utilization Management (UM) Work plan: A written document, updated and revised annually, that evaluates the overall effectiveness of the Utilization Management Program.

Utilization Management (UM) Work plan Evaluation: A written document, updated and revised annually, that evaluates the overall effectiveness of the Utilization Management (UM) Program.

Vision Services Plan (VSP) Provider: An optometrist or ophthalmologist who is duly licensed in California and has a subcontract with VSP to provide Vision Services to Members.

Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT): A survey administered both to individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons.

Waste: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Well-Managed: An assessment, which may include a clinical assessment, that determines that the Member's eligible chronic conditions are already well-managed – to the extent that HHP services are not medically necessary and will not significantly change the Member's health status. This includes participation in other CalOptima Health programs that are not Medicaid-funded that may be available and for which the Member is eligible. For disenrollment from HHP, the Member must be deemed well enough managed to the extent that the Member or the CB-CME determines HHP is no longer medically necessary and the member is no longer appropriate for the program, even for the maintenance level of services.

Wheelchair: A wheelchair may be a:

1. Manual wheelchair;
2. Power mobility device (PMD);
3. Power-assisted vehicle (POV); or
4. Push rim activated device.

Wheelchair Provider: A contracted provider, acting within his or her scope of practice, to furnish wheelchairs, SPCs, and related accessories to Members. The wheelchair provider ensures the wheelchair, SPCs, and accessories furnished are appropriate for the Member's medical and functional needs and may adjust or modify the furnished items as appropriate.

Withdrawal: A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

Women's Health Specialist: A gynecologist, certified nurse midwife, or other qualified health care practitioner, as defined by the Balanced Budget Act.

Workforce: Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for CalOptima Health is under the direct control of CalOptima Health, whether or not they are paid by CalOptima Health.

Workforce Member: Has the meaning in 45, Code of Federal Regulations Section 160.103 including: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

Working Aged Member: A Member who is at least sixty-five (65) years of age or older, currently works for an employer with twenty (20) or more employees and has health insurance coverage through the employer's group health plan. Working Aged Member is also a Member who is at least sixty-five (65) years of age or older and

has health insurance coverage under a currently employed spouse's employer group health plan if the employer has twenty (20) or more employees.

Working day(s): State calendar (State Appointment Calendar, Standard101) working day(s).

III. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2005	MA.1001	Glossary of Terms	OneCare
Revised	01/01/2008	MA.1001	Glossary of Terms	OneCare
Revised	06/01/2011	MA.1001	Glossary of Terms	OneCare
Revised	11/01/2011	MA.1001	Glossary of Terms	OneCare
Revised	05/01/2013	MA.1001	Glossary of Terms	OneCare
Revised	10/01/2013	MA.1001	Glossary of Terms	OneCare
Revised	04/01/2014	MA.1001	Glossary of Terms	OneCare
Revised	04/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	05/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	06/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	07/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	08/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	09/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	10/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	11/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	12/01/2016	MA.1001	Glossary of Terms	OneCare
Revised	02/01/2017	MA.1001	Glossary of Terms	OneCare
Revised	06/01/2017	MA.1001	Glossary of Terms	OneCare
Revised	12/01/2017	MA.1001	Glossary of Terms	OneCare
Revised	01/01/2020	MA.1001	Glossary of Terms	OneCare
Revised	02/01/2021	MA.1001	Glossary of Terms	OneCare
Revised	10/01/2021	MA.1001	OneCare Glossary of Terms	OneCare
Revised	11/01/2022	MA.1001	OneCare Glossary of Terms	OneCare
Revised	10/01/2023	MA.1001	OneCare Glossary of Terms	OneCare
Revised	01/01/2024	MA.1001	OneCare Glossary of Terms	OneCare