Policy:	GG.1301
Title:	**Comprehensive Care Management Process**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 12/20/2023*
Effective Date:	01/01/2007
Revised Date:	07/01/2023
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the guidelines for Case Management of Members who are enrolled in the Medi-Cal program, by CalOptima Health or a Health Network.

II. POLICY

A. Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

B. The goal of Complex Case Management is to help a Member regain optimum health or improve functional capability, in the least restrictive setting and in a cost-effective manner.

1. Complex Case Management is considered an opt-out program; all eligible Members have the right to participate or decline participation.

C. Complex Case Management involves a comprehensive initial assessment and evaluation of a Member's condition, functional capacity, determination of available benefits, resources, cultural and linguistic needs, Social Determinants of Health, and barriers to care. This information is analyzed for meaning and evaluated in a Member-centric manner in order to develop and implement an Individual Care Plan (ICP) with prioritized Member goals that are followed up on and monitored for progress.

D. CalOptima Health shall review and update its Case Management processes and resources to address Member needs, if necessary.

E. CalOptima Health or a Health Network shall ensure the provision of Case Management for CalOptima Health Members including Children with Special Health Care Needs (CSHCN) and those eligible with the California Children's Services (CCS) Program in accordance with CalOptima Health Policy GG.1330: Case Management - California Children's Services Whole-Child Model.

F. CalOptima Health or a Health Network shall ensure the provision of Case Management services for Members approved for Private Duty Nursing Services in accordance with CalOptima Health Policy GG.1352: Private Duty Nursing Care Management.

G. CalOptima Health or a Health Network shall ensure the provision of Case Management for CalOptima Health Members eligible for Enhanced Case Management in accordance with CalOptima Health Policy GG.1353 Enhanced Care Management Service Delivery.

H. With respect to Kaiser effective January 1, 2024, to ensure effective transition, facilitate continued access and minimize service interruptions for Members transitioning to another MCP, CalOptima shall ensure enhanced protections for Members in special populations, as defined in Section III.H.2.h.iv. of this Policy, do not face disruption in services as a result of DHCS contract changes effective January 1, 2024, with Medi-Cal Managed Care Plans (MCP) referred to as the MCP Transition.

1. CalOptima Health shall proactively coordinate Continuity of Care for Providers of special populations in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima.

2. CalOptima Health shall share supportive information by November 2, 2023, that includes but is not limited to results of available Member screening and assessment findings, Member Care Management Plans, and contact information for plan level staff and the care managers who served the transitioning Members.

a. Transfer of supportive data shall be completed by January 1, 2024, or within fifteen (15) calendar days of the Member changing to a new care manager, whichever is later.

b. Data sharing in accordance with the DHCS Continuity of Care data templates as outlined in the DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide.

III. PROCEDURE

A. CalOptima Health and a Health Network shall identify Members for Complex Case Management utilizing the following data sources:

1. Claims or encounter data;

2. Hospital or discharge data;

3. Pharmacy data;

4. Health information form;

5. Data collected through the utilization management (UM) process;

6. Data supplied by purchasers, such as the Breast and Cervical Cancer Treatment Program;

7. Data supplied by Member or caregiver; and

8. Data supplied by Practitioners.

B. CalOptima Health or a Health Network shall assess and provide Complex Case Management, as appropriate, to the following Members:

1. A Member who is high-risk, defined as:

a. A Member who has a medically complex condition, including the most frequently managed conditions; or

b. High risk groups, that may include, but are not limited to:

i. Spinal Injuries;

ii. Transplants;

iii. Cancer;

iv. Serious Trauma;

v. AIDS;

vi. Multiple chronic illnesses; and

vii. Chronic illnesses that result in high utilization.

2. A Member who has a complex social situation that affects the medical management of the Member's care;

3. A Member who requires an extensive use of resources; or

4. A Member who has an illness or condition that is severe, and the level of management necessary is very intensive.

C. CalOptima Health or a Health Network may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not qualify for Complex Case Management but would benefit from case management support. Care Coordination Case Management shall include:

1. Assistance with access to care issues;

2. Health and disease-specific education;

3. Referral to resources; and

4. Coordination of care with all Providers.

D. A Member may be referred to Complex Case Management through:

1. Medical Management program referral;

2. Discharge planner referral;

3. UM referral;

4. Member or caregiver referral;

5. Practitioner referral;

6. Community agency;

7. Health Network referral;

8. CalOptima Health shall communicate and provide details on the eligibility criteria and process for referral for case management through the following:

    a. Member newsletter;

    b. Provider communications, including but not limited to, the Provider newsletter; and

    c. Other materials or forums, as appropriate.

9. CalOptima Health or a Health Network may receive referrals by electronic transmission, telephone, or written correspondence.

E. The Complex Case Management process shall include, but not be limited to:

1. Standardized mechanisms to systematically identify a high-risk Member;

2. Access to Case Management by ensuring multiple avenues for referrals;

3. Process to inform an eligible Member of the right to decline participation in, or disenroll from, Case Management programs and services offered by CalOptima Health or a Health Network;

4. Complex Case Management system;

5. Documented Case Management process;

6. Initial assessment;

7. Process for providing ongoing Case Management;

8. Coordination of care to ensure provision of all Medically Necessary services;

9. Coordination of Targeted Case Management (TCM) to ensure provision of Medically Necessary services;

10. Coordination of carve-out services;

11. Coordination of PDN nursing in accordance with CalOptima Health Policy GG.1352: Private Duty Nursing Care Management, if applicable;

12. Coordination of services, both within and outside CalOptima Health's Service Area;

13. Coordination of Long Term Services And Supports (LTSS);

14. Coordination of behavioral health services;

15. Process for evaluating satisfaction with the Case Management program;

16. Process for measuring the effectiveness of Case Management; and

17. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI) Department.

F. Triage Process

1. Upon receipt of a referral for Case Management, CalOptima Health or a Health Network shall triage the referral for Case Management as follows:

    a. CalOptima Health or a Health Network shall triage an urgent referral within one (1) business day after receipt of the referral.

    b. CalOptima Health or a Health Network shall triage a standard referral within five (5) business days after receipt of the referral.

2. If, upon review of a referral for Care Coordination Case Management or Complex Case Management, CalOptima Health or a Health Network determines that a Member qualifies for Care Coordination Case Management or Complex Case Management, CalOptima Health or a Health Network shall:

    a. Contact the Member to obtain consent for Care Coordination Case Management or Complex Case Management services within one (1) business day for an urgent referral and within five (5) business days for a routine referral;

    b. Begin an initial assessment for the Member within thirty (30) calendar days of identification and complete within sixty (60) calendar days of identification; and

    c. Develop an ICP within thirty (30) calendar days of assessment.

G. Initial Member Assessment

1. CalOptima Health or a Health Network shall conduct a Member's initial assessment and evaluation in the following manner:

    a. Telephone interviews with the Member, the Member's Authorized Representative, or Member's family in accordance with CalOptima Health privacy and security policies for use and disclosure of health information, and in consultation with the Member. If the Member is unable to participate in the assessment, it may be completed by professionals on the care team, with assistance from the Member's family or caregiver;

    b. Consultation with the Member's PCP, specialist physician, or support staff, as needed;

    c. Review of Medical Records by a case manager, as needed;

    d. Consultation with CalOptima Health's or Health Networks' staff, as needed; or

    e. Consultation with a community agency, as needed.

2. CalOptima Health or a Health Network shall include the following in a Member's initial assessment and evaluation for Complex Case Management. CalOptima Health or a Health Network will document conclusions for each factor individually or in combination and the reasons for not addressing any specified factor (*e.g.,* life-planning in pediatric cases).

    a. Member's current health status, specific to identified health conditions and likely co-morbidities and their status; (e.g., high-risk pregnancy and heart disease, for Members with diabetes), and Member's self-reported health status. Information on the event or diagnosis that led to the Member's eligibility for Case Management, and current medications, including schedules and dosages.

b. Documentation of clinical history including:

   i. Dates;

   ii. Disease onset;

   iii. Past hospitalizations and major procedures, including surgery;

   iv. Significant past illnesses and treatment history;

   v. Relevant past medications related to the Member's condition; and

   vi. This factor does not require evaluation.

c. Assessment of Activities of Daily Living (ADL) related to, at a minimum, bathing, dressing, going to the toilet, transferring, feeding and continence. Documentation will reflect reason and type of assistance needed. If the Member needs no assistance with any ADLs, the case notes reflect this (e.g., "Member is fully independent with ADLs.").

d. Evaluation of the Member's behavioral health status, including cognitive functioning, and the ability to communicate, understand instructions, and process information about their illness as well as the presence of any mental health conditions or substance use disorders.

e. Assessment of Social Determinants of Health that may affect Members' ability to adhere to the care plan such as: economic and social status, social support networks, education and literacy, employment, physical and social environment, personal health practices, coping skills, beliefs and concerns about the condition, or treatment, perceived barriers to meeting treatment requirements, or access to transportation and financial barriers to obtaining treatment (as Social Determinants of Health are a combination of influences, assessment must include more than one (1) Social Determinant of Health).

f. Assessment of the Member's life planning activities, such as wills, living wills, or advance directives, health care powers of attorney, and Physician Orders of Life-Sustaining Treatment (POLST). CalOptima Health or a Health Network shall provide information on life planning/advance directives to the Member if these preferences are not on record, as appropriate. In the event that life planning activities are not appropriate, documentation must be present to support why the organization did not assess life planning activities.

g. Evaluation of cultural and linguistic needs, preferences, or limitations that may make it difficult to effectively communicate or for the Member to accept specific treatments. This evaluation shall include consideration of cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

h. Evaluation of visual and hearing needs, preferences, limitations, and characteristics that make it difficult for the care team to communicate effectively with the Member.

i. Evaluation for adequacy of caregiver resources, such as family or other support person involvement and role in decision making about the care plan. Documentation describes the resources in place, whether they are sufficient for the Member's needs, and notes specific gaps to address, if applicable.

j. Evaluation of available benefits, including the Member's eligibility and pertinent financial information regarding benefits. The assessment shall include a determination of whether the resources available to the Member are adequate to fulfill the treatment plan. Assessed benefits may include:

   i. Benefits covered by CalOptima Health, the Health Network, and by Providers;

   ii. Services carved-out by CalOptima Health and Health Networks; and

   iii. Services that supplement those the organization has been contracted to Provider (i.e., Community Mental Health).

k. Evaluation of community resources, including assessments of potential eligibility for community resources that supplement CalOptima Health resources, such as community mental health, transportation, wellness organizations, support groups, palliative care programs, nutritional support, and other national and community resources that would be helpful and appropriate to the Member's treatment plan.

3. Identification and referral of a Member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

   a. Children with Special Health Care Needs (CSHCN);

      i. Members may be identified upon enrollment and periodically based on available data.

      ii. Members may be identified through referrals.

      iii. Members and their representatives will be educated on available resources.

      iv. Members will be encouraged to participate in the Case Management process, including Whole Child Model Members, as described in Section III.E. of this policy.

   b. California Children's Services (CCS), as described in CalOptima Health Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program;

   c. Genetically Handicapped Persons Program (GHPP);

   d. Local Educational Agency (LEA);

   e. Regional Center of Orange County (RCOC);

   f. Section 1915(c) Home and Community-Based Services (HCBS) Waivers:

      i. AIDS Medi-Cal Waiver Program;

      ii. Assisted Living Waiver (ALW);

      iii. Home and Community-Based Alternatives (HCBA) Waiver;

      iv. Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver; and

      v. Self-Determination Program.

g. Specialty Mental Health Services, as described in CalOptima Health Policy GG.1103: Specialty Mental Health Services;

h. OCHCA Tuberculosis Program (Direct Observation Therapy); and

i. Long Term Services and Supports, including:

i. Community-Based Adult Services (CBAS);

ii. In-Home Support Services (IHSS); and

iii. Multipurpose Senior Services Program (MSSP).

H. Individual Care Plan (ICP) and Ongoing Management

1. A case manager shall develop, implement, and modify a Member's ICP in collaboration with the Member, Member's Provider, and/or their caregiver. A case manager may also develop, implement, and modify a Member's ICP in collaboration with the Member's Authorized Representative, members of the interdisciplinary care team, and/or specialist, when feasible.

2. CalOptima Health and a Health Network shall include the following elements in a Member's ICP:

a. Prioritized goals using high/low, numeric rank or other similar designation that consider the Member's and caregiver's goals, preferences, and desired level of involvement in the Case Management plan, and shall include goals personalized to meet a Member's specific needs, including the following:

i. Timeframe for re-evaluation;

ii. Resources to be utilized, including the appropriate level of care;

iii. Planning for continuity of care, including transition of care and transfers between settings;

iv. Collaborative approaches to be used, including family participation; and

v. Evaluating Member's personal preferences.

b. Identification of barriers to meeting goals, or compliance with ICP:

i. Barrier analysis shall include issues such as language, or literacy, lack of or limited access to reliable transportation, lack of understanding of condition, lack of motivation, financial or health insurance issues, cultural or spiritual beliefs, hearing, or vision, limits, and psychological impairment.

ii. Documentation of assessment for barriers, even if none identified.

c. Coordination of carved out services and referrals to appropriate community resources and agencies, including but not limited to HCBS waivers.

d. Facilitation of Member referrals to appropriate resources, and a follow-up process to determine whether Members act on referrals, including referrals to external resources, including but not limited to HCBS waivers.

e. Development of a schedule for follow-up and communication with a Member, which may include, but not be limited to, counseling, follow-up after referral to a Medical Management program, follow-up after referral to a health resource, and education self-management support.

   i. When and how a case manager will follow up with a Member after facilitating a referral to a health resource shall be documented. When follow-up is not appropriate, this determination shall be documented.

   ii. Documentation of the next scheduled Member contact and contact method.

f. Development and communication (e.g., orally or written) of a self-management plan that is acknowledged and agreed to by the Member. Self-management plans are actions the Member agrees to take to manage a condition or circumstance. Self-management plans are based on instructions or materials provided to Members or their caregivers. Member self-management plan of activities includes, but is not limited to:

   i. Maintaining a prescribed diet;

   ii. Charting daily readings (e.g., weight, blood sugar); or

   iii. Changing a wound dressing, as directed.

g. Assessment of progress towards meeting Case Management plans and goals and overcoming barriers to care. The process includes reassessing and adjusting the care plans and its goals, as needed.

h. Planning for Continuity of Care or transition of care when benefit coverage ends. CalOptima Health or a Health Network shall:

   i. Identify transitioning Members who are receiving approved services, but whose benefit coverage will end while still needing Medically Necessary care;

   ii. Identify available community resources and alternative care; and

   iii. Notify and educate transitioning Members regarding alternative care and community resources.

   iv. Provide Continuity of Care for special populations as defined by DHCS and outlined below, in accordance with Section II.H. of this policy:

      1. Adults and children with authorizations to receive Enhanced Care Management (ECM) services;

      2. Adults and children with authorizations to receive Community Supports;

      3. Adults and children receiving Complex Care Management;

      4. Enrolled in 1915(c) waiver programs;

      5. Receiving in-home supportive services (IHSS);

      6. Children and youth enrolled in California Children's Services (CCS)/CCS Whole Child Model;

7. Children and youth receiving foster care, and former foster youth through age nineteen to twenty-five (19-25);

8. In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, and hepatitis B and C;

9. Taking immunosuppressive medications, immunomodulators, and biologics;

10. Receiving treatment for end-stage renal disease (ESRD);

11. Living with an intellectual or developmental disability (I/DD) diagnosis;

12. Living with a dementia diagnosis;

13. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous twelve (12) months;

14. Pregnant or postpartum (within twelve (12) months of the end of a pregnancy or maternal mental health diagnosis);

15. Receiving specialty mental health services (adults, youth, and children);

16. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality;

17. Receiving hospice care for the duration of the terminal illness;

18. Receiving home health;

19. Residing in Skilled Nursing Facilities (SNF);

20. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD);

21. Receiving hospital inpatient care for the duration of the acute condition;

    a. CalOptima Health or a Health Network shall contact the PCP, when informed by prior MCP, of Members receiving care management who are known to be receiving inpatient care.

    b. CalOptima Health shall inform the receiving MCP of Members known to be receiving inpatient care by December 22, 2023, and refresh daily through January 9, 2024.

22. Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023;

23. Newly prescribed DME (within thirty (30) days of January 1, 2024) and

24. Members receiving Community-Based Adult Services.

3. A Member shall actively participate in the development of his or her ICP, in accordance with his or her individual physical and psychosocial capabilities.

4. CalOptima Health or a Health Network shall re-evaluate and update a Member's ICP based on the Member's level of complexity and clinical needs.

5. CalOptima Health and a Health Network shall terminate Complex Case Management for a Member when the Member:

    a. Achieves ICP goals;

    b. Becomes ineligible for Case Management; or

    c. Declines Case Management.

I. Targeted Case Management (TCM)

1. CalOptima Health and a Health Network may identify and refer a Member to the Orange County Health Care Agency (HCA) for Department of Health Care Services (DHCS) TCM services when the individual falls into one of the identified target populations below, has undergone a CalOptima Health Case Management assessment, and meets criteria outlined below:

    a. Children under age twenty-one (21).

    b. Medically fragile individuals.

    c. Individuals at risk of institutionalization.

    d. Individuals in jeopardy of negative medical, or psycho-social, outcomes.

    e. Individuals with a communicable disease.

2. CalOptima Health and a Health Network may identify and refer a Member for DHCS TCM services when the Member meets one (1) or more of the following criteria:

    a. Member is determined to be in need of case management services for non-medical needs.

    b. CalOptima Health has determined that the Member has demonstrated an on-going inability to access CalOptima Health services.

    c. CalOptima Health has determined that Member would benefit from TCM face-to-face case management.

    d. CalOptima Health has concerns that the Member has an inadequate support system for medical care.

    e. CalOptima Health has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the CalOptima Health care plan.

3. A Member who is referred and not accepted for TCM shall receive comparable Case Management services through CalOptima Health or a Health Network.

4. CalOptima Health shall ensure there is no duplication of services for Members who are enrolled in both TCM through the HCA, and complex or care coordination case management through CalOptima Health or a Health Network.

    a. Data feed from DHCS when available is evaluated routinely to identify Members open in TCM and Case Management.

    b. For Members who have both a TCM case manager and a CalOptima Health or Health Network case manager, the case managers shall share information vital to the care of the Member, which may include information, assessments, and care plans, and ensure non-duplication of services.

J. CalOptima Health and a Health Network shall utilize Case Management systems that support Case Management, by utilizing the following methods:

    1. MCG evidence-based clinical guidelines or algorithms to guide case managers through assessment and ongoing management of a Member;

    2. A documentation process that includes automated notation of the staff members' identification, date, and time of entry, and records each action or interaction with the Member, Primary Care Practitioner (PCP), or Provider; and

    3. Automated prompts and reminders for next steps and follow-up care and contact scheduled with the Member.

K. CalOptima Health and a Health Network shall provide Practitioners and Members, or caregivers as applicable, with written information about the Case Management program, to include the following:

    1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a Member;

    2. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and

    3. Information regarding how CalOptima Health or the Health Network works with a Member in the Case Management program.

L. On an annual basis, CalOptima Health shall evaluate Member satisfaction with CalOptima Health's or the Health Network's Case Management program. CalOptima Health shall use the following to evaluate Member satisfaction:

    1. Obtaining Member feedback;

    2. Analyzing Member complaints and inquiries; and

    3. Reporting the results of the evaluation to the Quality Assurance Committee (QAC).

M. CalOptima Health shall monitor a Health Network's Case Management program, in accordance with this Policy and CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Health Contract for Health Care Services
C. Coordination and Provision of Public Health Care Services Contract
D. CalOptima Health Policy GG.1101: California Children's Services (CCS) Whole Child Model – Coordination with County CCS Program
E. CalOptima Health Policy GG.1103: Specialty Mental Health Services
F. CalOptima Health Policy GG.1325 Continuity of Care for Members Transitioning into CalOptima
G. CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
H. CalOptima Health Policy GG.1352: Private Duty Nursing Care Management
I. CalOptima Health Policy GG.1532: Enhanced Care Management Service Delivery
J. CalOptima Health Policy GG.1619: Delegation Oversight
K. Case Management Society of America (CMSA): Standards of Practice for Case Management
L. National Committee for Quality Assurance (NCQA) 2022 PHM 5: Complex Case Management
M. Department of Health Care Services (DHCS) 2024 Medi-Cal Managed Care Plan Transition Policy Guide, Issued 08/07/2023
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-005 (Revised): California Children's Service Whole Child Model Program
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-018: Managed Care Health Plan Transition Policy Guide
Q. Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21
R. Title 22, California Code of Regulations (C.C.R.), §51185

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency	Response
09/09/2015	Department of Health Care Services (DHCS)	NR-90
01/20/2016	Department of Health Care Services (DHCS)	NR-90
06/21/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/07/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/14/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
06/03/2021	Regular Meeting of the CalOptima Board of Directors [Ratification]

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2010	GG.1301	Case Management Process	Medi-Cal
Revised	08/01/2011	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2013	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2014	GG.1301	Complex Case Management Process	Medi-Cal
Revised	04/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	11/01/2015	GG.1301	Complex Case Management Process	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2016	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	07/01/2017	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	05/01/2021	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	06/01/2022	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	03/01/2023	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	07/01/2023	GG.1301	Comprehensive Care Management Process	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	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.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Children with Special Health Care Needs (CSHCN)	Children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
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 includes Basic Case Management.
Complex Case Management Eligible Member	Members who are at high-risk; defined as having medically complex conditions that may include the following but is not limited to: 1. Spinal Injuries; 2. Transplants; 3. Cancer; 4. Serious trauma; 5. AIDS; 6. Multiple chronic illnesses; or 7. Chronic illnesses that result in high utilization. Or Member with a medical condition and a complex social situation that affects the medical management of the Member's care and requires an extensive use of resources.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Health 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.

Term	Definition
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Medical Management Program	For purposes of this policy: Disease management programs, utilization management programs, health information lines or similar programs that can identify needs for Complex Case Management and are managed by organization or vendor staff.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
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.
Private Duty Nursing (PDN)	An Early Periodic Screening, Detection, and Treatment (EPSDT) Supplemental Service that includes Medically Necessary services provided to Members who require continuous in-home nursing care.
Service Area	The county or counties that CalOptima Health is approved to operate in under the terms of the DHCS contract. Currently, this covers Orange County, California.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.

Term	Definition
Targeted Case Management	Services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.