Policy:	AA.1270
Title:	**Certification of Document and Data Submissions**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Michael Hunn 11/19/2024*
Effective Date:	07/01/2017
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process for certification of data, information, and documentation submitted to the Department of Health Care Services (DHCS) by CalOptima Health.

II. POLICY

A. In accordance with Title 42, Code of Federal Regulations (CFR), Sections 438.604 and 438.606 and contractual requirements, CalOptima Health shall certify data, information, and documentation submitted to DHCS.

B. CalOptima Health shall submit a completed and signed DHCS-approved certification statement on CalOptima Health letterhead by the final business day of each month to DHCS.

1. The signatory to the signed certification statement shall be the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on his or her behalf. The CEO or CFO shall remain ultimately responsible for the certification and the data, information, and documentation submitted by CalOptima Health to DHCS.

2. The certification statement shall apply to all data, information, and documentation submitted to DHCS, as follows:

   a. Encounter data as set forth in Title 42 CFR Section 438.604(a)(1);

   b. Provider network 274 data;

   c. Other documentation and data submitted to DHCS describing CalOptima Health's accessibility and availability of services, including network adequacy;

   d. Data submitted for the purpose of determining CalOptima Health's capitation rates, such as the rate development templates (RDT) and supplemental requests to support the rate setting process;

e. Data submitted for the purpose of determining CalOptima Health's Medical Loss Ratio (MLR);

f. Documentation submitted to DHCS on a monthly, quarterly, or annual basis related to CalOptima Health's financial status;

g. Ownership and control information, including ownership and control information for Subcontractors, Downstream Subcontractors, and Network Providers as required under Title 42, CFR Sections 438.602(c), 438.608(c)(2), and 455.104.

h. Annual report of overpayment recoveries as required in 42 CFR, section 438.608(d)(3);

i. Documentation confirming compliance with CalOptima Health's interoperability requirements and DHCS All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule;

j. Monthly and quarterly template data;

k. Monthly number of members enrolled in Dual Eligible Special Needs Plans (D-SNP); and

l. Any other data, information or documentation related to the performance of CalOptima Health's obligations under its contract with DHCS upon notification from DHCS that such data, information, or documentation, must be certified.

3. The certification statement shall include the following:

a. The current month during which all data, information, and documentation submitted to DHCS is certified;

b. Reference all types of data, information, and documentation as described in Section II.B.2 of this Policy;

c. A statement that the data, information, and documentation to which the certification applies is accurate, complete, and truthful to CalOptima Health's best information, knowledge, and belief; and

d. Signature of the CEO, CFO, or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on their behalf.

III. PROCEDURE

A. Submissions to DHCS not via RAC

1. In limited instances, certain CalOptima Health departments submit data, information, and documentation to DHCS not via the Regulatory Affairs & Compliance (RAC) Department, but instead either directly or via another CalOptima Health Department (e.g., Information Technology Services). Additionally, in limited instances, certain CalOptima Health departments oversee automated processes that result in the submission of data, information, and documentation directly to DHCS. In either of these scenarios, the following shall occur:

a. A Designee from each CalOptima Health department responsible for data, information, and documentation submitted to DHCS, not via the RAC Department, shall submit an

attestation to the RAC Department no later than three (3) business days prior to the end of the month, in any month(s) during which such information is submitted to DHCS.

i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME][MONTH YEAR] Attestation (Submissions not via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

B. Submissions to DHCS via RAC

1. In most instances, CalOptima Health departments submit data, information, and documentation to the RAC Department that in turn completes the submission(s) to DHCS.

a. In these instances, a Designee from each CalOptima Health department responsible for data, information, and documentation shall include an attestation to accompany each submission of required data, information, or documentation to the RAC Department.

i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME]_[REPORT NAME(S)]_ Attestation (Submissions via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

iii. RAC shall conduct a cursory review of the submitted reports, prior to submission to DHCS, to verify that applicable instructions and/or technical specifications have been followed. On a quarterly basis, each business area responsible for reporting will receive feedback on data quality and timeliness via a report card. Repeated quality and timeliness issues may result in a request for corrective action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

C. CalOptima Health's Provider Relations Department shall collect monthly data attestations from each delegated Health Network for data, information, and documentation submitted to CalOptima Health.

D. Based on these internal and Health Network attestations, the RAC Department shall submit the signed certification statement as required by DHCS and pursuant to Section II.B. of this Policy.

IV. ATTACHMENT(S)

A. Document and Data Attestation - Attestation (Submissions via RAC)
B. Document and Data Attestation - Attestation (Submissions not via RAC)
C. Document and Data Attestation - FAQs

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy HH.2005: Corrective Action Plan
C. CalOptima Health State Medicaid Agency Contract (SMAC) with DHCS for Dual Eligible Special Needs Plan (D-SNP)
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-005: Certification of Document and Data Submissions
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
F. Title 42, Code of Federal Regulations (C.F.R), §§438.602, 438.604, 438.606, 438.608, and 455.104.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/31/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/23/2019	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2017	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2018	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	07/01/2019	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2020	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	08/01/2021	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	12/31/2022	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	09/01/2023	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	11/07/2024	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. Appeal also includes the review of at-risk determinations made under a drug management program in accordance with § 423.153(f).
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: 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.
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.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Term	Definition
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: 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.
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.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.