Policy:	FF.1003
Title:	**Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 02/21/2025*
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Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines CalOptima Health's payment methodologies for a Provider or Practitioner that provides Covered Services to a Member for which CalOptima is financially responsible.

II. POLICY

A. Non-contracted hospitals, non-contracted Practitioners, and non-contracted Ancillary Service Providers shall not be eligible to participate in any CalOptima Health incentive payment programs.

B. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations (CCR), Section 51002.

C. CalOptima Health shall recover, or reimburse, overpayments in accordance with CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible.

III. PROCEDURE

A. Hospital Payment: Subject to all applicable Claims policies and Utilization Management (UM) policies, CalOptima Health shall reimburse a hospital that provides Covered Services to a Member for which CalOptima Health is financially responsible, as follows:

1. Contracted Hospital: CalOptima Health's reimbursement to a CalOptima Health Contracted Hospital for Covered Services provided to a Member for which CalOptima Health is financially responsible, shall be based on CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Direct Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group.

2. Non-Contracted Hospital: CalOptima Health's reimbursement to a non-contracted hospital for Covered Services provided to a Member for which CalOptima Health is financially responsible, that has received appropriate authorization, unless exempt from such authorization, in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima

Health Direct and CalOptima Health Community Network Providers, or the Shared Risk Group's Prior Authorization policies, is as follows:

a. Outpatient Emergency and Non-Emergency Services: CalOptima Health shall reimburse non-contracted outpatient Covered Services provided to a Member for which CalOptima Health is financially responsible, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

b. Emergency Inpatient Services: For dates of service on or after July 1, 2013, CalOptima Health shall reimburse non-contracted emergency inpatient Covered Services provided to a Member for which CalOptima Health is financially responsible using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

c. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima Health shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima Health shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

d. Non-emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between CalOptima Health and a hospital, CalOptima Health shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior Authorization is required for all non-emergency inpatient services.

e. Interim claims shall be accepted for stays that exceed twenty-nine (29) calendar days. CalOptima Health shall adopt the DHCS FFS per diem amount of six hundred dollars ($600). Upon discharge, a hospital shall submit a single, admit-through-discharge claim. CalOptima Health shall calculate the final payment by using the APR-DRG method and shall be reduced by the interim payment(s) that were previously made.

f. Out of State Hospitals: Except as provided in Section III.A.2.d.i. of this Policy, CalOptima Health shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code, for dates of service on or after July 1, 2013.

g. Border Hospitals: CalOptima Health shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, with respect to admissions occurring on or after July 1, 2015. CalOptima Health may pay a lower negotiated rate agreed to by the hospital.

3. Skilled Nursing Facilities (SNF) and Nursing Facilities (NF): For the contract periods from January 1, 2023, to December 31, 2025, CalOptima Health shall reimburse a Network Provider furnishing institutional long-term care services to a Member the amount the Provider could collect if the Member accessed those services in the Medi-Cal FFS delivery system, as defined

by DHCS in the Medi-Cal State Plan, a Directed Payment Initiative, and other applicable guidance. As used in this provision, "institutional long-term care services" has the same meaning as set forth in the CalAIM Terms and Conditions and includes, at a minimum, all the following services:

a. Skilled Nursing Facility (SNF) services;

b. Subacute facility services;

c. Pediatric subacute facility services; and

d. Intermediate care facility services,

e. This reimbursement requirement applies only to SNF services as defined in Title 22, CCR, Sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a Member's stay, which include:

   i. SNF services as set forth in Title 22, CCR, Section 51123(a) to include:

      a) Room and board;

      b) Nursing and related care services; and

      c) Commonly used items of equipment, supplies and services as set forth in Title 22, CCR, Section 51511(b).

   ii. Leave-of-absence days as set forth in Title 22, CCR, Section 51535.

   iii. Bed holds as set forth in Title 22, CCR, Section 51535.1.

f. The reimbursement requirement does not apply to any other services provided to a Member receiving SNF services such as, but not limited to, services outlined in Title 22, CCR, sections 51123(b) and (c) and 51511(c) and (d), SNF services provided by an Out-of-Network Provider, or services that are not provided by a Network Provider of SNF services.

   i. Non-qualifying services are not subject to the terms of this state directed payment and are payable by CalOptima Health in accordance with the terms negotiated between CalOptima Health and the Provider.

   ii. The reimbursement requirement applies only to payments made directly for SNF services rendered, and does not apply to other types of payments, including, but not limited to, Provider incentive and pay-for-performance payments.

4. Non-Emergency Non-Authorized Services: CalOptima Health shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, or the Shared Risk Group's authorization policies, for which such authorization has not been secured.

5. Local Health Departments (LHD): CalOptima Health shall reimburse Local Health Department (LHD) for the administration fee for immunizations given to Members after receipt of claims and supporting records, in accordance with CalOptima Health Policy GG.1116: Pediatric Preventative Services.

    a. Other than LHDs, CalOptima Health shall reimburse Providers for immunizations if CalOptima Health and Provider enter into an agreement.

6. If a Member changes Health Networks, including CalOptima Health Direct, for purposes of this provision, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this Policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Health Medi-Cal program. Subject to all applicable CalOptima Health Claims and UM policies, CalOptima Health shall reimburse a Practitioner providing Covered Services to a Member as follows:

1. Contracted Practitioner: CalOptima Health shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and CalOptima Health.

2. Non-contracted Practitioner: CalOptima Health's reimbursement to a non-contracted Practitioner for Covered Services provided to a Member for which CalOptima Health is financially responsible, that has received appropriate authorization, unless exempt from such authorization, in accordance with CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers and FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible, shall be based on the following:

    a. Emergency Services: CalOptima Health shall reimburse a non-contracted Practitioner that provides emergency Covered Services to a Member, for which CalOptima Health is financially responsible at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

    b. Non-Emergency Services: CalOptima Health shall reimburse a non-contracted Practitioner for Covered Services rendered to a Member of CalOptima Health Direct, or a Member enrolled in a Shared Risk Group, for Covered Services for which CalOptima Health is financially responsible on a fee-for-service basis as follows:

        i. For dates of service on or after January 1, 2011, CalOptima Health shall reimburse professional services at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

        ii. Except as otherwise provided in this subsection, CalOptima Health shall reimburse a physician who is a California Children's Service (CCS) Program-paneled Provider, and who is recognized as a specialist physician by CCS, at one hundred forty percent

(140%) of the CalOptima Health Medi-Cal Fee Schedule for Covered Services rendered to a Member who is less than twenty-one (21) years of age.

iii. CalOptima Health shall reimburse technical component of pathology, clinical laboratory, and radiology services at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

iv. CalOptima Health shall reimburse Child Health and Disability Prevention (CHDP) services, as set forth in CalOptima Health Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

v. CalOptima Health shall reimburse injectables at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vi. For dates of service on or after January 1, 2011, CalOptima Health shall reimburse Surgical and Incontinence Supplies at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

vii. CalOptima Health shall reimburse "By Report" procedure codes in the same manner as DHCS.

viii. CalOptima Health shall reimburse Family Planning Services at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

    a) CalOptima Health shall reimburse a provider, including a non-contracted provider, for a twelve (12)-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a Member's request by a qualified family planning provider or pharmacist with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.

ix. CalOptima Health shall reimburse diagnosis and treatment of a Sexually Transmitted Disease (STD) episode to a non-contracted provider including local health departments that provides treatment records or documentation of the Member's refusal to release Medical Records along with billing information at no less than the Medi-Cal FFS Rate.

x. CalOptima Health shall reimburse HIV Testing and counseling to a non-contracted provider who make reasonable efforts to report confidential test results in accordance with applicable law and regulation including but not limited to Health & Safety Code Section 121025 at no less than the Medi-Cal FFS Rate.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwives, licensed midwives and Certified Nurse Practitioners services as permitted within each practitioner's scope of practice, CalOptima Health shall reimburse facility and professional services at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program. If an appropriately licensed non-contracting Free Standing Birthing Center is used, CalOptima Health shall pay the Center's facility.

D. Abortion Services: Subject to all applicable CalOptima Health Claims Administration policies, CalOptima Health shall cover and reimburse the Providers of medical services and supplies incidental or preliminary to an abortion to a Member for which CalOptima Health is financially responsible as set forth in CalOptima Health policies GG.1118: Family Planning Services, Out-of-Network and GG.1508: Authorization and Processing of Referrals.

1. CalOptima Health shall reimburse non-contracted provider for abortion services at the MFFS rate unless, the non-contracted provider and CalOptima Health mutually agree to a different reimbursement rate.

E. Long-Term Care Services: CalOptima Health shall reimburse Long-Term Care (LTC) services for contracted Providers at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program subject to authorization requirements, in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

1. Long Term Care Intermediate Care Facility/Home for Individuals with Developmental Disabilities (ICF/DD): Effective January 1, 2024, CalOptima Health shall reimburse all medically Covered Services for Members residing or obtaining care in an ICF/DD home according to the agreed upon contract.

    a. CalOptima Health shall provide an invoicing process for Providers unable to submit electronic claims. ICF/DD Homes may submit invoices to CalOptima Health on the paper form of the UB-04. If CalOptima Health and an ICF/DD Home mutually agree to share invoice information using a different format, standard, or transmission method than what is described in this guidance, they may do so, though CalOptima Health may not exclude ICF/DD Homes from their networks due to an inability to consume, use, or exchange information beyond what is described.

2. Facility Payment:

    a. Medi-Cal FFS per diem rates may be updated by DHCS from time to time for specified dates of service. The Medi-Cal FFS per diem rate published for the latest dates of service remains effective for subsequent dates of services, until such time that an updated per diem rate is published for subsequent dates of service.

    b. CalOptima Health shall implement payment of the updated per diem rate on a prospective basis for all claims with applicable dates of service, received on or after thirty (30) working days of being notified by DHCS that the updated rates are published.

c. If additional amounts are owed retroactively to a Network Provider on any claims for applicable dates of service that were processed prior to CalOptima Health implementing the updated per diem rates on a prospective basis, then CalOptima Health shall pay any necessary retroactive adjustments within forty-five (45) working days after being notified by DHCS that the updated rates are published.

d. CalOptima Health shall retroactively reprocess claims for specified dates of service to effectuate the updated rate automatically, without requiring manual reprocessing or resubmission by the Network Provider.

e. Payments processes including timely payment of claims requirements for Network Providers also apply for Out-of-Network Providers when those dates of service were under continuity of care.

3. Share of Cost (SOC):

a. CalOptima Health shall process claims submitted by ICF/DD Homes, Skilled Nursing Facilities (SNFs), and Subacute Care Facilities consistent with the Medi-Cal guidelines for SOC outlined in the Medi-Cal LTC Provider Manual. When a Member has an SOC, the facility will subtract the SOC payment collected or obligated payment from the claim amount and submit the claim to CalOptima Health to pay the balance.

b. The Johnson v. Rank lawsuit, states that Medi-Cal Members, not their Providers, can elect to use the SOC funds to pay for necessary, non-covered, medical or remedial care services, supplies, equipment, and drugs (medical services) that are prescribed by a physician and part of the plan of care authorized by the Member's attending physician. The physician's prescriptions for SOC expenditures must be maintained in the Member's Medical Record. If a Member spends part of their SOC on necessary, noncovered, medical or remedial care services or items, the facility will subtract those amounts from a Member's SOC and collect the remaining SOC amount owned.

c. CalOptima Health shall maintain a process to verify that a Provider has correctly subtracted the applicable SOC amount for claims submitted for Members with a SOC.

    1. The Claims Department will review the value(s) in Box 39 of the UB04 claim form and ensure that SOC amount is accurately transferred into the adjudication system.

d. CalOptima Health shall maintain a process for handling claims where a Provider has not subtracted the correct SOC amount for claims submitted for Members with a SOC.

    1. The Claims Department will review the Automated Eligibility Verification System (AEVS) to retrieve the correct SOC amount.

        a. The correct SOC amount will be applied in the adjudication system to process claim appropriately.

e. CalOptima Health shall maintain a process for handling claims where the full SOC has not been deducted by the Provider due to Johnson v. Rank provisions.

1. The Claims Department will review the value in Box 80 of the UB04 claim form to determine the non-covered services (NCS) amount has been deducted from the full SOC amount and is accurately transferred into the adjudication system.

    a. Once determined that the NCS amount has been correctly subtracted from the full SOC amount, the claim will be processed in accordance with the established adjudication guidelines.

    b. If the Provider's calculations in Box 80 are found to be incorrect, the claim will be denied, and the Provider will be advised to bill according to the Provider manual and applicable guidelines.

F. Cognitive Assessments: Subject to all applicable CalOptima Health Administration policies, CalOptima Health shall cover and reimburse Providers who provide cognitive health assessments and who follow the following billing requirements, in accordance with DHCS All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older:

    1. Complete the DHCS Dementia Care Aware cognitive health assessment training prior to conducting the brief cognitive health assessment, in accordance with CalOptima Health Policy EE.1103: Provider Network Training;

    2. Administer the annual cognitive health assessment as a component of an E&M visit including, but not limited to an office visit, consultation, or preventive medicine service, in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities

    3. Document all of the following in the Member's Medical Records and have such records available upon request:

        a. The screening tool or tools that were used;

        b. Verification that screening results were reviewed by the Provider;

        c. The results of the screening;

        d. The interpretation of results; and

        e. Details discussed with the Member and/or authorized representative and any appropriate actions taken in regard to screening results.

    4. Use allowable CPT codes as outlined in the Medi-Cal Provider Manual.

G. Doula Services: Subject to all applicable CalOptima Health Claims and UM policies, CalOptima Health shall cover and reimburse the Providers of medical services and supplies incidental or preliminary to doula services to a Member for which CalOptima Health is financially responsible, in accordance with CalOptima Health GG.1707: Doula Services.

H. Dyadic Services: CalOptima Health shall reimburse Dyadic Care Services Providers, in accordance with their Network Provider contracts, DHCS APL 22-029: Dyadic Services and Family Therapy Benefit, and CalOptima Health Policy GG.1900: Behavioral Health Services:

1. Multiple Dyadic Services are allowed on the same day and may be reimbursed at the FFS rate. The Dyadic Behavioral Health (DBH) well-child visit must be limited to those services that are not already covered in the medical well-child visit, and any other service codes cannot be duplicative of services that have already provided in a medical well-child visit or a DBH well-child visit;

2. Dyadic caregiver service codes (screening, assessment, and brief intervention services provided to the parent or caregiver for the benefit of the child) may be billed by either the medical well-child Provider or the DBH well-child visit Provider, but not by both Providers, when the dyad is seen on the same day by both Providers;

3. Provider must submit billing for dyadic services with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual;

4. All Dyadic Services must be billed under the Medi-Cal ID of the Member under age twenty-one (21);

5. Tribal health programs (THPs), Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from CalOptima Health if Dyadic Care services are provided by a billable Provider, in accordance with DHCS APL 21-008: Tribal Federally Qualified Health Center Providers, or any superseding APLs; and

6. Dyadic Services may be reimbursed at the FFS rate established for services, if the service provided does not meet the definition of a THP, RHC, or FQHC visit, or exceeds frequency limitations. THP, RHC, and FQHC Providers can bill FFS for the four (4) Dyadic Services codes (H1011, H2015, H2027, and T1027) delivered in a clinical setting by Provider types named in the Non-Specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.

I. Street Medicine Services: CalOptima Health shall reimburse Street Medicine Providers according to the Medi-Cal FFS for appropriate and applicable services within their scope of practice, in accordance with DHCS APL 24-001: Street Medicine Provider: Definitions and Participation in Managed Care. Street Medicine Providers must comply with the billing provisions for Street Medicine Providers as applicable in FFS, including but not limited to, the Medi-Cal Provider Manual, and in accordance with CalOptima Health Policy GA.7110: Street Medicine.

1. If a Street Medicine Provider is an FQHC, they may be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located and are a billable clinic provider.

J. Telehealth Services: CalOptima Health shall reimburse existing Covered Services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes, in accordance with DHCS APL 22-007: Telehealth Services Policy, and subject to any existing treatment authorization requirements and may be provided via a Telehealth modality, in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology Enabled Services.

1. To ensure proper payment and record of Covered Services provided via Telehealth, all Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through both synchronous interactions and asynchronous store and forward telecommunications. The rate of reimbursement, unless otherwise agreed to by CalOptima Health and the Provider will be the same rate, whether a Covered Service is provided in-person or through Telehealth.

K. Targeted Rate Increase (TRI): CalOptima Health shall reimburse eligible Provider types for qualifying services at the TRI fee schedule rate, pursuant to paragraph 3 of Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan, for dates of service on or after January 1, 2024.

1. FQHC and RHC services do not qualify for reimbursement under the TRI Fee Schedule in the FFS delivery system and thus are not qualifying services for the purposes of this directed payment arrangement. CalOptima Health shall reimburse contracted FQHCs and RHCs in a manner that is no less than the level and amount of payment that CalOptima Health would make for the same scope of services if the services were furnished by another Provider type that is not an FQHC or RHC.

2. The Network Provider is reimbursed on a capitated basis, the CalOptima Health shall ensure the Network Provider receives reimbursement that provides payment that is equal to, or projected to be equal to, the TRI Fee Schedule rate for applicable services at minimum.

3. CalOptima Health shall ensure that eligible Network Providers receive no less than the applicable minimum fee schedule rates for qualifying services.

    a. In instances where the Network Provider is reimbursed on a per-service basis, this requirement applies at the procedure code level.

4. Qualifying services are reported using the specified HCPCS and CPT codes and are appropriate for the services being provided and reported to DHCS in Encounter Data pursuant to DHCS APL 14-019: Encounter Data Submission Requirements.

5. CalOptima Health shall make available to the Network Provider an itemization of the reimbursement adjustments in an electronic format must for retroactive adjustments to per-service or capitated reimbursements made to a Network Provider.

6. CalOptima Health shall have a formal procedure for the acceptance, acknowledgment, and resolution of Network Provider grievances related to the processing or non-payment of payments, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Compliant.

L. Immunization: Welfare and Institutions Code (W&I) section 14132.968 added Pharmacist Services as a Medi-Cal benefit, reimbursable under the authority of State Plan Amendment 18-0039. CalOptima Health shall reimburse the initiating and administering of immunizations as a pharmacist service when rendered to a Member for which CalOptima Health is financially responsible for, in the outpatient pharmacy setting, by a pharmacist who is trained and operating under a Board of Pharmacy protocol, as authorized in B&P section 4052.8 and as described in 16 CCR section 1746.4, in the outpatient pharmacy setting are a reimbursable Medi-Cal benefit.

1. The rendering pharmacist must be enrolled in Medi-Cal as an Ordering, Referring, and Prescribing (ORP) provider for claim reimbursement.

2. Starting August 1, 2024, and retroactive to January 1, 2023, pharmacies also have the option of submitting a medical claim to CalOptima Health for the vaccine administration fee in lieu of submitting a pharmacy claim to Medi-Cal Rx for this fee.

3. The initiation fee, which includes consultation and assessment of need for vaccination, billed under pharmacist services as a medical benefit will be billed only to CalOptima Health for CalOptima Health Members.

M. Clinical Trials: CalOptima Health shall cover routine patient care costs for Members participating in a qualifying clinical trial including items and services furnished in connection with participation by Members in a qualifying clinical trial pursuant to Title 42 United States Code (USC), Section 1396d(a)(30), and California Welfare and Institutions Code (W&I) Section 14132.98 and in accordance with CalOptima Health Policy GG.1125 Clinical Trials.

1. A qualifying clinical trial is a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

2. Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

3. A Provider or Practitioner shall obtain Prior Authorization for reimbursement of routine patient care costs related to a CalOptima Health Direct or CalOptima Health Community Network (CHCN) Member's participation in a Clinical Trial, in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

N. Provider Preventable Conditions (PPC): CalOptima Health shall reimburse treatment of PPC when the PPC existed prior to the initiation of treatment for the Member by the Network Provider in accordance with CalOptima Health Policy GG.1655: Reporting Provider Preventable Conditions (PPC).

1. CalOptima Health shall not reimburse a Network Provider for the treatment when the PPC did not exist prior to the initiation of treatment.

O. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable claims and UM policies, CalOptima Health shall reimburse an FQHC that provides Covered Services to a Member for which CalOptima Health is financially responsible, for Covered Services for which CalOptima Health is financially responsible, as follows:

1. Contracted FQHC: CalOptima Health shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and CalOptima Health. CalOptima Health's contracted rates for an FQHC shall not be less than CalOptima Health's contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC:

    a. CalOptima Health shall reimburse a non-contracted FQHC for Covered Services rendered to a Member for which CalOptima Health is financially responsible, for Covered Services for which CalOptima Health is financially responsible at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

    b. CalOptima Health shall reimburse a non-contracted FQHC for CHDP services, as set forth in CalOptima Health Policy GG.1116: Pediatric Preventive Services, at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

    c. CalOptima Health shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

O. American Indian Health Service Program Payment: Subject to all applicable claims and UM policies, CalOptima Health shall reimburse an Indian Health Service Facility that provides Covered Services to a Member for which CalOptima Health is financially responsible, for Covered Services for which CalOptima Health is financially responsible as follows:

1. Contracted American Indian Health Service Program:

    a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, CalOptima Health shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

    b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and CalOptima Health and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with CalOptima Health, CalOptima Health shall reimburse the program at the negotiated rate.

    c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, CalOptima Health shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: CalOptima Health shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, CalOptima Health shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to

receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. CalOptima Health shall ensure that the following criteria are met for receipt of payments:

    a. The American Indian Health Service Program provider must be identified by DHCS;

    b. Service must be a Covered Service included in CalOptima Health's contract with DHCS;

    c. Except as provided in Section III.L.5. of this Policy, only one rate payment per day, per category, shall be allowed within the following three (3) categories as set forth in the California Medicaid State Plan Supplement 6. Attachment 4.19-B. This allows for a maximum of three (3) payments per day, one (1) from each category:

        i. Medical health visit;

        ii. Mental health visit;

        iii. Ambulatory visit.

5. Tribal FQHC: Effective January 1, 2021, CalOptima Health shall reimburse a Tribal FQHC Provider, including an Indian Health Care Provider enrolled as an Indian Health Services Memorandum of Agreement (IHS-MOA) clinic that elected to participate in Medi-Cal as a Tribal FQHC Provider in accordance with the Alternate Payment Methodology (APM), which is set at the All-Inclusive Rate (AIR). Once enrolled with DHCS, the DHCS will add the new Trial FQHC Provider and the following reimbursement requirements:

    a. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent (80%) of the Medicare FQHC prospective payment system rate.

    b. For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)."

    c. CalOptima Health shall ensure that the following criteria are met for receipt of payments:

        i. The Tribal FQHC provider must be identified by DHCS;

        ii. Service must be a Covered Service included in CalOptima Health's contract with DHCS;

        iii. As set forth in DHCS All Plan Letter 21-008: Tribal Federally Qualified Health Center Providers and California State Plan Amendment to Attachment 4.19-B, CA-20-0044, a Tribal FQHC Provider shall be reimbursed at the applicable rate for up to three (3) visits per day, per Member in any combination of different visits in the following visit categories:

            a) Medical health visit;

b) Mental health visit; and

c) Ambulatory visit.

d. A Tribal FQHC Provider may expand its service locations outside of the clinic facility when services are provided by clinic providers or provider contracting with the Tribal FQHC Provider.

6. Certain Covered Services shall be reimbursed outside of the OMB or APM rate, including Non-Medical Transportation, Non-Emergency Medical Transportation, and pharmacy services.

P. Ancillary Service Provider Payment: Subject to all applicable claims and UM policies, CalOptima Health shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member for which CalOptima Health is financially responsible for Covered Services for which CalOptima Health is financially responsible as follows:

1. CalOptima Health shall reimburse a contracted Ancillary Service Provider based on the terms and conditions of the contract between such contracted Ancillary Service Provider and CalOptima Health.

2. CalOptima Health shall reimburse a non-contracted Ancillary Service Provider for Covered Services rendered to a Member for which CalOptima Health is financially responsible, at one hundred percent (100%) of the CalOptima Health Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

Q. Directed Payment: CalOptima Health shall make specified directed payments to a Provider or Practitioner eligible to receive the directed payments for qualifying Covered Services provided to a Member for which CalOptima Health is financially responsible, in accordance with the requirements of CalOptima Health Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to a Shared Risk Group Members when CalOptima Health is Financially Responsible for the Qualifying Services.

R. Financial Responsibility for Medically Necessary Post-Stabilization Services: Subject to compliance with all applicable Claims policies and UM policies, including but not limited to, authorization, medical records, coding and billing requirements, CalOptima Health's financial responsibility for Medically Necessary Post-Stabilization Services provided to a Member of CalOptima Health Direct or a Member enrolled in a Shared Risk Group are as follows:

1. Contracted Provider: CalOptima Health is financially responsible for Medically Necessary Post-Stabilization Services rendered by a contracted Provider to a Member for which CalOptima Health is financially responsible in accordance with their contract.

2. Non-Contracted Provider:

a. CalOptima Health is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member for which CalOptima Health is financially responsible that are:

i. Pre-approved by CalOptima Health or the Shared Risk Group, as applicable.

ii. Not pre-approved by CalOptima Health or the Shared Risk Group, as applicable, but administered to maintain the Member's stabilized condition within one (1) hour of a request to CalOptima Health or the Shared Risk Group for Prior Authorization of further Post-Stabilization Services.

b. CalOptima Health is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member for which CalOptima Health is financially responsible that are not pre-approved by CalOptima Health or the Shared Risk Group, as applicable, but administered to maintain, improve, or resolve the Member's stabilized condition if:

i. CalOptima Health or the Shared Risk Group, as applicable, does not respond within thirty (30) minutes after receipt of a written request for Prior Authorization for Medically Necessary Post-Stabilization Services, that fully complies with CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers and/or GG.1508: Authorization and Processing of Referrals, as applicable;

ii. CalOptima Health or the Shared Risk Group, as applicable, cannot be contacted; or

iii. A representative of CalOptima Health or the Shared Risk Group, as applicable, and the treating physician cannot reach an agreement concerning the Member's care, and CalOptima Health or the Shared Risk Group's plan physician is not available for consultation. In this situation, CalOptima Health or the Shared Risk Group must give the treating physician the opportunity to consult with CalOptima Health or the Shared Risk Group's plan physician, as applicable, and the treating physician may continue with care of the Member until such plan physician is reached or one (1) of the criteria in 42 C.F.R. § 422.113(c)(3) is met, as set forth in Section III.H.2.d of this Policy.

c. Notwithstanding Section III.H.2.b.i. of this Policy, CalOptima Health has the authority to disapprove payment for the delivery of Post-Stabilization Services or the continuation of the delivery of Post-Stabilization Services, if CalOptima Health or the Shared Risk Group notifies the non-contacted Provider of the denial of a request prior to the commencement of the delivery or during the delivery of Post-Stabilization Services in accordance with the requirements of CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers and/or GG.1508: Authorization and Processing of Referrals, as applicable. In that event and subject to Section III.H.3.c.i. of this Policy, CalOptima Health shall not be obligated to pay for the continuation of Post-Stabilization Services from and after the time CalOptima Health or the Shared Risk Group, as applicable, provides such notice.

i. CalOptima Health shall pay for all Medically Necessary health care services provided to a Member which are necessary to maintain the Member's stabilized condition up to the time that CalOptima Health or the Shared Risk Group, as applicable, effectuates the Member's transfer or the Member is discharged.

d. CalOptima Health's financial responsibility for Medically Necessary Post-Stabilization Services not pre-approved ends when:

i. CalOptima Health or the Shared Risk Group's plan physician, as applicable, with privileges at the treating hospital assumes responsibility for the Member's care;

ii. CalOptima Health or the Shared Risk Group's plan physician, as applicable, assumes responsibility for the Member's care through transfer;

iii. A representative of CalOptima Health or the Shared Risk Group, as applicable, and the treating physician reach an agreement concerning the Member's care; or

iv. The Member is discharged.

e. Denial and Transfer: In the event that CalOptima Health or a Shared Risk Group denies a Prior Authorization request for Post-Stabilization Services from a non-contracted Provider, and transfers the Member to a contracted Provider, payment shall be made for Medically Necessary health care services furnished to the Member to maintain his or her stabilized condition up to the time that the Member's transfer is effectuated.

f. No Prior Authorization Request. If a non-contracted Provider does not seek a Prior Authorization request for Post-Stabilization Services from CalOptima Health or the Shared Risk Group, then CalOptima Health is only financially responsible for Emergency Services rendered, and not for Post-Stabilization Services.

3. The CalOptima Health Claims Department shall contact the CalOptima Health UM Department for clarification of any questions regarding an authorization of Post-Stabilization Services using the internal routing process.

S. A Provider or Practitioner that renders Covered Services to a Member for which CalOptima Health is financially responsible for Covered Services for which CalOptima Health is financially responsible shall submit claims to CalOptima Health, in accordance with CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Health and Safety Code, §1797.1, and 121025
B. California Welfare and Institutions Code, §14105.28
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health Policy FF.1002: CalOptima Health Medi-Cal Fee Schedule
E. CalOptima Health Policy FF.1004: Payments for Hospitals Contracted to Serve a CalOptima Health Direct Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group
F. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible

G. CalOptima Health Policy FF.2011: Directed Payments for Qualifying Services Rendered to CalOptima Health, Health Network Members When Health Networks are Financially Responsible for the Qualifying Services
F. CalOptima Health Policy FF.2012: Directed Payments for Qualifying Services Rendered to CalOptima Health Direct Members or to Shared Risk Group Members when CalOptima Health is Financially Responsible for the Qualifying Services
G. CalOptima Health Policy GA.7110: Street Medicine
H. CalOptima Health Policy GG.1116: Pediatric Preventive Services
I. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
J. CalOptima Health Policy GG.1125: Clinical Trials
K. CalOptima Health Policy GG.1213: Community Health Worker Services
L. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
M. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
N. CalOptima Health Policy GG.1707: Doula Services
O. CalOptima Health Policy GG.1900: Behavioral Health Services
P. CalOptima Health Policy HH.1101: CalOptima Health Provider Compliant
Q. CalOptima Health Policy HH.2022: Record Retention and Access
R. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
S. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
V. Department of Health Care Services (DHCS) All Policy Letter (APL) 13-004: Rates For Emergency And Post-Stabilization Acute Inpatient Services Provided By Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013 (Supersedes APL 07-014)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-019: Encounter Data Submission Requirements
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020: American Indian Health Programs (Revised 09/24/2024)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-019: Family Planning Services Policy for Self-Administered Hormonal Contraceptives (Supersedes APL 16-003)
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (Supersedes APL 16-017)
AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020 (Supersedes APL 16-016)
BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers
CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older
DD. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-029: Dyadic Services And Family Therapy Benefit (Revised 03/20/2023)
EE. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-007: Telehealth Services Policy (Supersedes APL 19-009)
FF. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services

(Supersedes APL 22-031) (Revised 10/22/2024)

GG. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-001: Street Medicine Provider: Definitions and Participation in Managed Care (Supersedes APL 22-023)

HH. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services (Supersedes APL 22-022)

II. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-007: Targeted Provider Rate Increases

JJ. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements (Supersedes APL 18-004 and 16-009)

KK. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-009: Skilled Nursing Facilities - Long Term Care Benefit Standardization and Transition Of Members To Managed Care (Supersedes APL 23-004)

LL. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-010: Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-027)

MM. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities For Individuals With Developmental Disabilities - Long Term Care Benefit Standardization And Transition Of Members To Managed Care (Supersedes APL 23-023)

NN. Department of Health Care Services (DHCS) Policy Letter (PL) 96-009: Sexually Transmitted Disease Services in Medi-Cal Managed Care

OO. Manual of Current Procedural Terminology (CPT®), American Medical Association

PP. Social Security Act, §1932(b)(2)(D)

QQ. Title 22, California Code of Regulations, §§51002, 51123(a), 51511(b), 51535, 51535.1, 55000, and 55140(a)

RR. Title 28, California Code of Regulations, §1300.71.4

SS. Title 42, Code of Federal Regulations, §422.113(c)

TT. Title 42, United States Code, §1396u-2(h)(2)(C)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/10/2009	Department of Health Care Services (DHCS)	Approved as Submitted
03/10/2014	Department of Health Care Services (DHCS)	Approved as Submitted
07/06/2016	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
12/04/2020	Department of Health Care Services (DHCS)	Approved as Submitted
10/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted
07/15/2022	Department of Health Care Services (DHCS)	File and Use
02/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
07/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted
12/20/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
01/07/2025	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
06/04/2002	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
06/05/2007	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
06/03/2008	Regular Meeting of the CalOptima Board of Directors
10/02/2008	Regular Meeting of the CalOptima Board of Directors
11/06/2008	Regular Meeting of the CalOptima Board of Directors
11/05/2009	Regular Meeting of the CalOptima Board of Directors
06/06/2013	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/06/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2009	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	01/01/2011	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	10/01/2012	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	07/01/2013	FF.1003	Payment for Covered Services Rendered to CalOptima Direct Members	Medi-Cal
Revised	03/01/2015	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	04/01/2016	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/01/2017	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	10/04/2018	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/04/2020	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	05/05/2022	FF.1003	Payments for Covered Services Rendered to a Member of CalOptima Direct, CalOptima Community Network or a Member Enrolled in a Shared Risk Group	Medi-Cal
Revised	02/01/2023	FF.1003	Payments for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	03/01/2023	FF.1003	Payments for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	01/01/2024	FF.1003	Payments for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	09/01/2024	FF.1003	Payments for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	12/31/2024	FF.1003	Payments for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	02/01/2025	FF.1003	Payments for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible	Medi-Cal

IX. GLOSSARY

Term	Definition
American Indian Health Services Program	Programs operated by Indian Health Care Providers with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations, Sections 41515.2 through 41518.9.
CalOptima Health Direct	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
CalOptima Health Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima Health for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima Health is responsible.
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 woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Health Members, the CHDP Program is incorporated into CalOptima Health's Pediatric Preventive Services Program.

Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a

Term	Definition
	Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning;

Term	Definition
	4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Indian Health Care Provider (IHCP)	As set forth in 42 CFR § 438.14 (a), a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC § 1603).
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.

Term	Definition
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.
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.
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.
Non-Emergency Medical Transportation (NEMT)	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Non-Medical Transportation (NMT)	Transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.
Out-of-Network Provider	A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Services	Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on CalOptima Health for a CalOptima Health Direct Member or on CalOptima Health and the Shared Risk Group for a Member enrolled in that Shared Risk Group for which CalOptima Health is financially responsible for the Covered Services in accordance with the Division of Financial Responsibility.
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), Licensed Midwife, Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.

Term	Definition
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200.
Rural Health Clinic	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Shared Risk Group	A Health Network that accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.
Share of Cost (SOC)	The amount of health care expenses that a recipient must pay for each month before they become eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.
Street Medicine	Street Medicine is a set of health and social services designed to specifically address the unique needs and circumstances of individuals experiencing unsheltered homelessness, to be delivered directly to them in their own environment, and more specifically, places that are not intended for human habitation.
Street Medicine Provider	Street Medicine Provider refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.
Tribal Federally Qualified Health Center Provider or Tribal FQHC Provider	An Indian Health Care Provider operating under the authority of the Tribal Indian Self-Determination and Education Assistance Act and participating in Medi-Cal as a Tribal FQHC (using CMS criteria). California State Plan Amendment (SPA) 20-0044 establishes Tribal FQHCs provider type in Medi-Cal.