Policy:	HH.1107
Title:	**Fraud, Waste, and Abuse Investigation and Reporting**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/ Michael Hunn 11/20/2024*
Effective Date:	09/01/2004
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process to investigate, and report suspected Fraud, Waste, or Abuse (FWA) committed by a Member, Provider, a CalOptima Health Employee, First Tier, Downstream, and Related Entities (FDRs), and CalOptima Health's Health Networks involving a CalOptima Health program, in accordance with federal and state regulations and contractual requirements.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward FWA by a Member, a Provider, an Employee, an FDR and/or a Health Network.

B. CalOptima Health shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include, but are not limited to, federal and state False Claims Acts and Anti-Kickback laws, the federal Exclusion Statute, the federal Administrative Remedies Act, the federal Social Security Act laws prohibiting inducements to Members, the federal Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

C. CalOptima Health Employees and its FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith.

D. CalOptima Health shall establish a process for timely and reasonable investigation and reporting of suspected FWA, in accordance with this Policy.

E. CalOptima Health's Office of Compliance shall coordinate all activities associated with the investigation and reporting of suspected FWA.

F. CalOptima Health's Office of Compliance shall maintain a system for the review of suspect claims to detect and prevent FWA, in accordance with federal and state regulations, and to identify resulting overpayments for recoupment, in accordance with CalOptima Health Policies HH.5000: Provider Overpayment Investigation and Determination, and HH.1105: Fraud, Waste and Abuse Detection.

G. CalOptima Health's Office of Compliance shall collaborate with the CalOptima Health Pharmacy Management Department, and other appropriate departments, to reduce controlled substances and opioid-related Fraud, Abuse, and misuse, as outlined in CalOptima Health Policies GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, and MA.6104: Opioid Medication Utilization Management.

1. The CalOptima Health SIU shall investigate suspected FWA of prescription drugs, and/or controlled substances, in accordance with this Policy.

H. CalOptima Health shall coordinate and cooperate with the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid (CMS), and law enforcement agencies related to any FWA investigations, or audits.

I. CalOptima Health shall conduct preliminary research of any allegation of suspected FWA and shall report suspected FWA to the appropriate agency, in accordance with its contracts with DHCS and/or CMS, and this Policy. All allegations received shall be documented in a FWA tracking log within one (1) business day.

J. Upon determination of validity of the allegation, CalOptima Health shall refer suspected FWA to DHCS and/or CMS for further investigation, as appropriate.

K. CalOptima Health's Office of Compliance shall maintain a database and a uniform filing system to maintain suspected FWA referrals, including reports, investigations, and correspondence, in accordance with CalOptima Health's Compliance Program. CalOptima Health's Office of Compliance shall ensure appropriate confidentiality of case files, or other documentation relating to any investigation of a suspected FWA case.

L. CalOptima Health's Office of Compliance shall function as the liaison between CalOptima Health and DHCS, CMS, appropriate state Medical Boards, the State Board of Pharmacy, other licensing entities, law enforcement, prosecuting agencies, as appropriate, and other relevant entities.

M. CalOptima Health's Office of Compliance shall report the status and results of suspected FWA investigations to CalOptima Health's Compliance Committee, as appropriate.

N. CalOptima Health's Office of Compliance shall investigate, and report suspected FWA, in accordance with this Policy.

O. All reports of suspected FWA are kept confidential to the extent permitted by applicable law and circumstances.

III. PROCEDURE

A. Reporting FWA to CalOptima Health:

1. CalOptima Health shall provide a method for CalOptima Health Employees, FDRs, and Members to anonymously report suspected FWA to the Office of Compliance. CalOptima Health Employees and its FDRs may call the Compliance and Ethics Hotline at 1-855-507-1805 to anonymously report concerns regarding Fraud, Waste, and Abuse.

2. A CalOptima Health Employee who detects suspected FWA may also complete a Suspected Fraud or Abuse Referral Form and transmit it to the Office of Compliance.

3. An FDR with a contractual obligation to report suspected FWA shall notify CalOptima Health of suspected FWA, in accordance with the terms and conditions of its contract and this Policy.

4. Any State, Federal, and/or other Managed Care Plans referrals to CalOptima Health of potential FWA are investigated and reported to DHCS's Program Integrity Unit (PIU) and shall remain confidential, as needed.

B. Investigation of FWA:

1. When a report is received concerning suspected FWA, the Office of Compliance shall verify the suspected activity using data from reports, including, but not limited to, the following:

   a. CalOptima Health's Compliance and Ethics Hotline, or other reporting mechanisms;

   b. Claims data history;

   c. Encounter data;

   d. Member and Provider complaints, appeals, and grievance reviews;

   e. Medical Record audits;

   f. Pharmacy data;

   g. Utilization Management reports;

   h. Provider utilization profiles;

   i. Member interviews and/or service verification surveys;

   j. Employee interviews;

   k. Provider and/or provider staff interviews;

   l. Monitoring and auditing activities;

   m. Monitoring external health care FWA cases and determining if CalOptima Health's FWA program can be strengthened with information gleaned from the case activity; and/or

   n. Internal and external surveys, reviews, and audits.

2. All reports of suspected FWA shall be preliminarily researched to build on the information provided in the allegation in the attempt to have sufficient data for conducting an investigation. CalOptima Health has a target goal of ten (10) business days to determine if sufficient information can be garnered for an allegation in order to conduct an investigation.

   a. Information needed to begin an investigation is considered on a case-by-case basis and may include:

      i. Subject name;

      ii. Verifiable data;

iii. Relativity/applicability to CalOptima Health; and/or

iv. Sufficient detail to determine the allegation or the potential offender.

a) An example would be if an allegation is anonymously reported and the complainant simply states his provider committed fraud, but did not give a name of a provider, there is insufficient information to conduct an investigation.

b) If there is insufficient information to proceed with conducting an investigation, the Office of Compliance may refer it to another department, agency, or other appropriate entity, and shall document the case for tracking.

1) An example would be a member grievance (complaint) that staff at a provider's office are rude. The case would not be considered an allegation of FWA and would be forwarded to the Grievances and Appeals Resolution Services (GARS) department.

3. For allegations of CalOptima Health Employee's misconduct investigations that involve potential FWA, a referral to SIU should be made by the CalOptima Health staff involved in the initial Employee misconduct investigation. Each referral is considered on a case-by-case basis. The referral to SIU for Employee misconduct investigations will authorize the SIU to have primary responsibility of the Employee misconduct investigation as it relates to potential FWA.

4. When the FWA Investigator is able to determine the probable root cause of the suspected FWA, the information will be documented in the internal case management tracking log and may be reported during the quarterly Compliance Committee meetings.

5. If an investigation finds no component of FWA, and the actions investigated are more appropriately classified as non-compliance, the remediation shall be handled in accordance with CalOptima Health Policies HH.2005: Corrective Actions Plans, HH.2002: Sanctions, or GA.8022: Performance and Behavior Standards.

6. CalOptima Health shall issue corrective actions to Employees and its FDRs related to validated instances of FWA. Corrective actions will be monitored by the Compliance Committee, or the Human Resources Department, as appropriate. Corrective actions may include financial sanctions, regulatory reporting, performance improvement plans, or termination. If the validated instance of FWA is determined to be criminal in nature, actions may also include a referral to law enforcement.

7. The Office of Compliance will initiate review and discussion at the first Compliance Committee Meeting following the date when significant instances of FWA are identified.

8. If CalOptima Health's SIU investigation yields findings involving an FDR, the SIU shall notify the impacted CalOptima Health department(s), CalOptima Health, Health Network(s), and/or business partners, as needed.

9. For investigations involving suspected FWA of prescription drugs, including controlled substances, the CalOptima Health SIU will collaborate with the CalOptima Health Pharmacy Management Department during the investigation. If the investigation yields findings related to FWA, the SIU will work with Pharmacy Management and Quality Improvement to implement actions in accordance with CalOptima Health Policies MA.5013: Pharmacy Audits and Reviews, GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities, GG.1615:

Corrective Action Plan for Practitioners, and MA.6104: Opioid Medication Utilization Management.

10. The SIU shall enter all documentation related to any suspected FWA case into the internal case management tracking log within one (1) business day and document the final disposition once the case has been determined to be closed.

C. Notices of a Credible Allegation of Fraud

1. For investigations involving situations when DHCS and/or CMS notifies CalOptima Health that a Credible Allegation of Fraud has been found against an FDR or Provider, CalOptima Health must take one (1) or more of the following options and submit any supporting documentation as requested or appropriate to DHCS and/or CMS:

   a. Terminate the FDR or Provider from its network;

   b. Temporarily suspend the FDR or Provider from its network pending resolution of the Fraud allegation;

   c. Temporarily suspend payment to the FDR or Provider pending resolution of the Fraud allegation; and/or

   d. Conduct additional monitoring including audits of the FDR's or Provider's claims history and future claims submissions for appropriate billing.

2. For investigations involving situations when there is a Credible Allegation of Fraud against a pharmacy, CalOptima Health shall work with the PBM and/or appropriate regulatory agency to take one or more of the options above.

D. Reports of changes to a Member's circumstances which may impact a Member's Medi-Cal eligibility are promptly reported to DHCS and/or the local Social Service Agency, as needed.

E. CalOptima Health Reporting to Regulators:

1. For investigations involving Medi-Cal, CalOptima Health shall report to DHCS PIU all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, or Members. CalOptima Health shall conduct, complete and report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within ten (10) business days of the date CalOptima Health first became aware of, or is on notice of, such activity.

2. For investigations involving OneCare or PACE programs, CalOptima Health shall report to DHCS PIU in accordance with Section III.E.1. above, as well as to CMS National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by CalOptima Health Employees, FDRs, or Members. CalOptima Health shall conduct a preliminary investigation and report to the NBI MEDIC within thirty (30) calendar days of the date potential Fraudulent or abusive activity is identified.

3. For investigations involving the Medi-Cal program, the referral shall be submitted on a Medi-Cal Complaint Report (MC609) that can be sent to DHCS PIU via secure email. Any completed investigations and quarterly FWA reports will be made to the DHCS PIU via secure email.

4. For investigations involving the OneCare or PACE programs, the referral shall be submitted via the CMS program integrity web-based portal. For investigations involving OneCare or PACE program where the allegation is exclusively a compromised identification, the referral to CMS shall be submitted on an I MEDIC ID Compromised ID Report Form via secure email, secure facsimile, Federal Express with a tracking number, or certified mail. CalOptima Health shall submit applicable police reports, investigation documentation (background, interviews, etc.), Member information, Provider enrollment data, confirmation of services, list items or services furnished by Provider, pharmaceutical data, and any other pertinent information.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)
B. Form MC609 - Confidential Medi-Cal Complaint Report form
C. CalOptima Health Referral to MEDIC
D. CalOptima Health Referral to MEDIC ID Compromised

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Compliance Plan
C. CalOptima Health Contract for Health Care Services
D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GA.8022: Performance and Behavior Standards
H. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
I. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners
J. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
K. CalOptima Health Policy HH.2002: Sanctions
L. CalOptima Health Policy HH.2005: Corrective Action Plan
M. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
N. CalOptima Health Policy MA.5013: Pharmacy Audits and Reviews
O. CalOptima Health Policy MA.6104: Opioid Medication Utilization Management
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required Following Notice of a Credible Allegation of Fraud
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-026: Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse (Supersedes APL 19-012)Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) All Plan Letter (APL) 03-011: Fraud Referral Procedure to Audits and Investigations (A&I)
R. Medicare Managed Care Manual, Chapters 9 and 21
S. Title 31, United States Code, §3730(h), Civil actions for false claims
T. Title 42, Code of Federal Regulations, §455.2
U. Welfare and Institutions Code, §14043.1(a)
V. 2022 CMS Part C and D Final Rule

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/01/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
06/01/2023	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	09/01/2004	HH.1107	Fraud and Abuse Investigation and Reporting	Medi-Cal
Revised	01/01/2008	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2010	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	02/01/2013	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	07/01/2014	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	09/01/2015	HH.1107	Fraud, Waste and Abuse Investigation and Reporting	Medi-Cal
Revised	06/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal
Revised	12/01/2016	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	06/01/2023	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.1107	Fraud, Waste, and Abuse Investigation and Reporting	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Covered Service	Medi-Cal: 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:

Term	Definition
	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 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

Term	Definition
	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. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Credible Allegation of Fraud	A Credible Allegation of Fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline complaints. (2) Claims data mining. (3) Patterns identified through Provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability, and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortiums, and Health Maintenance Organizations.

Term	Definition
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
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.
Medically Necessary or Medical Necessity	Medi-Cal: 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. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

Term	Definition
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	A beneficiary enrolled in a CalOptima Health Program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient Compliance Programs; performing drug utilization review; and operating disease management programs.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.