Policy:	GG.1355
Title:	**CalAIM Community Supports**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 09/24/2024*
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Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This Policy describes the eligibility criteria for CalOptima Health Community Supports and identifies the requirements for the referral, authorization, and provision of CalOptima Health Community Supports under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

II. POLICY

A. Community Supports are medically appropriate, cost-effective alternatives provided as a substitute to services covered under the California Medicaid State Plan and are delivered by a different Provider or in a different setting than those described in the State Plan. These services shall not reduce or jeopardize Member access to State Plan services.

B. Community Supports can only be covered if the State determines they are medically appropriate and cost-effective alternatives and are identified and authorized in CalOptima Health's Medi-Cal Contract with the Department of Health Care Services (DHCS).

C. A Member's participation in CalOptima Health Community Supports is optional; CalOptima Health shall not require a Member to use CalOptima Health Community Supports.

D. CalOptima Health must not use Community Supports to reduce, discourage, or jeopardize Members' access to California Medicaid State Plan services.

E. CalOptima Health shall ensure the underlying State Plan Covered Services are made available to the Member, if Medically Necessary for the Member, or if the Member declines CalOptima Health Community Supports.

F. CalOptima Health may not adopt a more narrowly defined eligible population for Community Supports than outlined in the DHCS Community Supports Policy Guide.

G. To the extent a Member is receiving care or case management, CalOptima Health Community Supports should be integrated with care or case management, including Enhanced Care Management (ECM) when appropriate.

H. CalOptima Health shall provide Community Support Services for Members who meet the eligibility criteria as defined in Attachment B of this Policy.

I. Effective no sooner than January 1, 2022, CalOptima Health shall offer four (4) selected DHCS-approved CalOptima Health Community Supports, listed below and further defined in Attachment A of this Policy.

1. Housing Transition Navigation Services;

2. Housing Deposits;

3. Housing Tenancy and Sustaining Services; and

4. Recuperative Care (Medical Respite).

J. Effective no sooner than July 1, 2022, CalOptima Health shall offer five (5) selected DHCS-approved CalOptima Health Community Supports, listed below and further defined in Attachment A of this Policy.

1. Short-Term Post-Hospitalization Housing;

2. Medically-Tailored meals;

3. Sobering Centers;

4. Personal Care/Homemaker Services; and

5. Day Habilitation Program

K. Effective no sooner than January 1, 2023, CalOptima Health shall offer five (5) selected DHCS-approved CalOptima Health Community Supports, listed below and further defined in Attachment A of this Policy.

1. Respite Services;

2. Nursing Facility Transition/Diversion to Assisted Living Facilities (Elderly and Adult Residential Facilities);

3. Community Transition Services/Nursing Facility Transition to a Home;

4. Environmental Accessibility Adaptions (Modifications); and

5. Asthma Remediation.

L. CalOptima Health will notify DHCS six (6) months prior to implementation of any additional community support offering and include submission of an updated CalAIM Model of Care to DHCS.

M. CalOptima Health shall provide CalOptima Health Community Supports training and technical assistance to Community Supports Providers, through in-person sessions, webinars, and/or telephone calls, as necessary and in accordance with CalOptima Health Policy EE.1103: Provider Network Training and Section III.C. of this Policy.

N. A Community Supports Provider shall not receive payment from CalOptima Health for the provision of any CalOptima Health Community Supports not authorized by CalOptima Health or a Health Network.

O. To be eligible for participation in CalOptima Health Community Supports, a Member must meet the DHCS-specific requirements for the CalOptima Health Community Supports under consideration, as described in Attachment B of this Policy.

P. CalOptima Health or a Health Network shall accept referrals for CalOptima Health Community Supports from Providers, other community-based entities, Members and/or family members.

Q. CalOptima Health or the Health Network shall use systems and processes capable of tracking CalOptima Health Community Supports referrals, access to CalOptima Health Community Supports, and Grievances and Appeals.

    1. CalOptima Health or the Health Network shall track CalOptima Health Community Supports referrals and will support Community Supports Provider access to systems and processes allowing them to track and manage referral and Member information.

R. CalOptima Health follows DHCS requirements to use of Electronic Visit Verification (EVV) for Medicaid-funded Personal Care Services (PCS) and Home Health Care Services (HHCS) for in-home visits by a Provider in accordance with DHCS All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements.

    1. CalOptima Health will ensure contracted Community Supports Providers (Personal Care and Homemaker Services, Recuperative Care (Medical Respite), and Day Habilitation Programs) will be trained in the Electronic Visit Verification (EVV) systems in accordance with DHCS APL 22-014: Electronic Visit Verification Implementation Requirements.

    2. Providers that use the EVV system for services must capture and transmit the following six mandatory data components: verify each type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

        a. Any alternate EVV system utilized must comply with all business requirements and technical specifications, including the ability to capture and transmit the required data elements to the EVV aggregator.

S. CalOptima Health shall regularly monitor and provide oversight of Community Supports Providers to ensure compliance with regulatory, contractual, and business requirements as described in Section III.M. of this Policy.

T. A Community Supports Provider or Member, as applicable, shall be entitled to Grievance and Appeals procedures.

U. CalOptima Health Community Supports are subject to the State Fair Hearings process, in accordance with CalOptima Health Policy HH.1108: State Hearing Process and Procedures.

V. CalOptima Health or a Health Network shall ensure that Providers do not bill for Community Health Workers (CHW) services and Community Supports for the same Member for the same time period in accordance with DHCS APL 24-006: Community Health Worker Services Benefit.

III. PROCEDURE

A. Informing Members and Providers

1. CalOptima Health shall inform Members and Providers about current and newly added CalOptima Health-offered Community Supports and the referral process, including how to submit the CalOptima Health Community Supports request through:

    a. Member communication such as the Member Handbook, CalOptima Health website, Member Orientation meetings, and communication with CalOptima Health representatives (e.g., Customer Service staff, case managers); and

    b. Provider communication including but not limited to the CalOptima Health website (www.caloptima.org), CalOptima Health Provider Manual, CalOptima Health Policies and Procedures, CalOptima Health Community Announcement, other educational materials, as well as through community events and other regularly scheduled CalOptima Health stakeholder forums.

2. CalOptima Health may discontinue a specific CalOptima Health Community Supports annually, with notice to DHCS, at the end of the calendar year, except in cases where the CalOptima Health Community Supports is terminated due to Member health, safety, or welfare concerns.

    a. CalOptima Health shall ensure CalOptima Health Community Supports that were authorized for a Member prior to the discontinuation of that specific CalOptima Health Community Supports are not disrupted by a change in CalOptima Health Community Supports offerings, either by completing the authorized services or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet their needs.

    b. CalOptima Health shall publicize the service end date and provide at least ninety (90) calendar days' notice to Members. Notice to Members affected by a decision to discontinue a specific CalOptima Health Community Supports shall include:

        i. The change and timing of discontinuation; and

        ii. The procedures that will be used to ensure completion of the authorized CalOptima Health Community Supports or a transition into other Medically Necessary services.

    c. CalOptima Health shall implement a plan for continuity of care for Members receiving the discontinued CalOptima Health Community Supports.

B. Provider Medi-Cal Enrollment and Credentialing or CalOptima Health's Vetting Process

1. If a State level enrollment pathway exists for the Community Supports Provider, CalOptima Health shall verify that the Community Supports Provider is enrolled in Medi-Cal, pursuant to relevant DHCS APLs, including APL 22-013 Provider Credentialing/Recredentialing and Screening/Enrollment. CalOptima Health shall also credential the Community Supports Provider in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Re-Assessment of Organizational Providers, as applicable.

2. If no Medi-Cal/Medicaid enrollment pathway exists, CalOptima Health shall verify the qualifications of the Provider or Provider organization to ensure they meet the standards and capabilities to be a Community Supports Provider in accordance with CalOptima Health Policies GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring. CalOptima Health shall also consider the following factors as part of CalOptima Health's process for vetting the qualifications and experience of Community Supports Providers:

    a. Ability to receive referrals from CalOptima Health and Health Networks for the authorized CalOptima Health Community Supports service;

    b. Sufficient experience to provide services similar to the specific CalOptima Health Community Supports they are contracted to provide within the service area;

    c. Ability to submit claims or invoices for CalOptima Health Community Supports using standardized protocols;

    d. Business licensing that meets industry standards;

    e. Capability to comply with all reporting and oversight requirements;

    f. History of fraud, waste, and/or abuse;

    g. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

    h. History of liability claims against the Community Supports Provider.

C. Provider Training

1. In addition to network Provider training requirements described in CalOptima Health's Medi-Cal Contract with DHCS, CalOptima Health will provide the CalOptima Health Community Supports training described below to Community Supports Providers, including through in-person sessions, webinars, and/or calls, as necessary:

    a. CalOptima Health Community Supports program overview, Community Supports Provider role, community resources and referrals, as well as operational and topic-specific trainings.

    b. Special populations, Social Determinants of Health, trauma-informed care, health literacy, data-sharing and reporting requirements will also be covered.

D. Identifying Members and Receiving Requests for CalOptima Health Community Supports

1. CalOptima Health and the Health Networks shall identify Members who will benefit from one or more CalOptima Health Community Supports by:

    a. Working with ECM Providers to identify Members receiving ECM who could benefit from CalOptima Health Community Supports;

    b. Proactively identifying Members who may benefit from the CalOptima Health Community Supports through review of available data indicating a Member meets specific eligibility criteria, as described in Attachment B of this Policy;

c. Accepting CalOptima Health Community Supports requests from Providers and other community-based entities; and

d. Accepting CalOptima Health Community Supports requests from a Member, family member, guardian, caregiver, and/or authorized support person.

2. CalOptima Health shall refer Members to a Community Supports Provider within two (2) business days of issuing authorization for the service.

   a. In the event a Community Supports Provider is at pre-determined capacity, CalOptima Health shall transfer the authorized CalOptima Health Community Supports service to another contracted Community Supports service Provider with capacity; and,

   b. CalOptima Health shall enter into a Letters of Agreement (LOA) with available, non-contracted Community Supports service Provider(s) if all contracted Community Supports service Providers are at pre-determined capacity.

3. CalOptima Health shall provide Medically Necessary Covered Services regardless of whether the Member has been offered Community Support, is currently receiving a Community Support, or has received a Community Support in the past.

4. CalOptima Health shall continuously monitor all Member utilization and Provider capacity for all Community Supports services to evaluate if additional Community Supports service Providers are needed to ensure equitable access for Members.

5. CalOptima Health will establish LOAs to appropriate Providers if needed to ensure timely access to Community Supports services.

6. If CalOptima Health's Community Supports service Provider network capacity is limited, CalOptima Health or a Health Network shall prioritize the initiation of CalOptima Health Community Supports to Members who are at greatest risk of a decline in current physical or mental health status.

E. Authorization of CalOptima Health Community Supports is required prior to the initiation of services.

1. CalOptima Health shall ensure timely processing of expedited and routine CalOptima Health Community Supports authorization requests in accordance with CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   a. An authorization request for CalOptima Health Community Supports may be expedited when a specific, time-limited indication for the service requested exists and is a critical component of appropriate delivery of the CalOptima Health Community Supports Provider.

      i. Recuperative Care Providers may issue a presumptive authorization for Recuperative Care services to a CalOptima Health or Health Network Member who meets the established criteria defined in Section III.I.4.b. of this Policy, Attachment of this Policy, and when delay of an authorization would be harmful to the Member.

b. No sooner than January 1, 2023, CalOptima Health will be responsible for authorizing Community Supports services for CalOptima Health Members through a centralized system.

c. CalOptima Health and Health Networks will ensure:

i. Member information is exchanged daily through a secured process; and

ii. Eligible Members are authorized Community Supports services timely and appropriately.

d. CalOptima Health shall ensure Street Medicine ECM providers are allowed expeditious referrals to ECM, in accordance with CalOptima Health Policies GA.7110: Street Medicine and GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.

2. For Members transitioning from other Medi-Cal Managed Care Plans (MCPs) previously identified and receiving Community Supports, CalOptima Health shall ensure Continuity of Care in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services and MA.6021a: Continuity of Care for New Members.

a. Transitioning Members actively receiving Community Supports shall not face disruption of services resulting from the MCP transition on January 1, 2024. Member eligibility and service authorizations shall be honored and not require reauthorization.

i. CalOptima Health shall honor all previous MCP authorizations for Community Supports when both MCPs offer the same Community Support.

ii. CalOptima Health shall maintain all authorizations for no less than the length of time originally authorized by the previous MCP, up to twelve (12) months beyond January 1, 2024, or longer if CalOptima Health chooses.

iii. CalOptima Health shall honor the authorized Community Support by the previous MCP in alignment with Medi-Cal Community Supports, or in Lieu of Services, Policy Guide. If the previous MCP's authorization exceeds the State-defined Community Support, CalOptima Health shall honor the greater authorized Community Support.

iv. If CalOptima Health does not offer a Community Support authorized by the previous MCP, CalOptima Health will assess the Member's needs addressed by the Community Support and coordinate care to the necessary services, including ECM, to ensure an appropriate transition of care and to prevent the need for higher acuity services.

1) If the previous MCP's Community Supports provider does not wish to enter into a contract with CalOptima Health's network or if both parties cannot come to an agreement, CalOptima Health shall offer CoC for provider agreement with the Community Supports provider for up to twelve (12) months.

2) If CalOptima Health's efforts do not result in an agreement with the Community Supports provider, CalOptima Health shall explain in writing to DHCS why the provider and CalOptima Health could not execute a contract or CoC for provider agreement.

3) If CalOptima Health confirms the Member's existing Community Supports provider is part of its network, agrees to join its network, or participates under a CoC provider agreement, CalOptima Health shall ensure the Member is connected with the existing Community Supports provider to ensure the Member's relationship with their Community Supports provider is not disrupted.

4) If CalOptima Health does not bring the Community Supports provider into its network or establish an agreement with the Community Supports provider, CalOptima Health shall transition the Member to an in-network Community Supports Provider.

b. CalOptima Health shall authorize the Member for Community Supports upon:

i. A direct request from the Member, the Member's family, or authorized representative to include an attestation from the Member.

ii. Review of Encounter data demonstrating utilization of available Community Supports in previous ninety (90) days.

c. CalOptima Health shall outreach to the Member, the Member's previous MCP, and/or the Community Supports Provider, as appropriate to mitigate gaps in care.

i. To the extent possible CalOptima Health shall utilize Member's pre-existing Community Supports Provider.

ii. If CalOptima Health confirms the Member's existing Community Supports Provider is part of its network, agrees to join the network, or participates under a Continuity of Care for provider agreement, CalOptima Health shall ensure the Member's relationship with their Community Supports Provider is not disrupted.

d. Members will be reassessed based on the following discontinuation criteria:

a) Member states they no longer wish to receive the service;

b) Provider is unable to reach Member after multiple attempts;

c) Member no longer requires the service or has completed service goals; or

d) Member is unresponsive or unwilling to engage with the Community Supports Provider. This can include instances when a Member's behavior or environment is unsafe for the Community Supports Provider.

3. CalOptima Health shall not authorize Community Supports for a Member who transitions from another MCP when the Community Support service is only available once in a Member's lifetime and/or if CalOptima Health does not provide the Community Support service which the Member had received from the Member's prior MCP.

4. CalOptima Health shall notify the requestor of CalOptima Health's decision regarding Community Supports service authorization in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

5. CalOptima Health shall monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory in accordance with Section III.M. of this Policy.

F. Sharing Information with Community Supports Providers

1. As part of the referral process to Community Supports Providers and consistent with federal, State, and, if applicable, local privacy and confidentiality laws, CalOptima Health shall ensure a Community Supports Provider has access to:

    a. Demographic and administrative information confirming the Member's eligibility and authorization for the requested service;

    b. Appropriate administrative, clinical, and social service information the Community Supports Provider may need to effectively provide the requested service; and

    c. Billing information necessary to enable the Community Supports Provider to submit claims or invoices to CalOptima Health.

2. CalOptima Health shall provide the following data elements to Community Supports Providers in a manner and format that is practical to each Community Supports Provider:

    a. Member assignment files, including but may not be limited to:

        i. Encounter and claims data;

        ii. Physical, behavioral, administrative and Social Determinants of Health data; and

        iii. Report of Community Supports Provider performance and quality metrics, as requested.

G. Community Supports Provider Responsibilities Upon Authorization

1. Community Supports Providers shall:

    a. Accept and act upon referrals for authorized CalOptima Health Community Supports, unless the Community Supports Provider is at pre-determined capacity.

    b. Conduct outreach to the referred Member for authorized CalOptima Health Community Supports as soon as possible, within twenty-four (24) hours of assignment, if possible.

        i. As part of service initiation, secure, document, and preserve evidence of Member agreement to receive CalOptima Health Community Supports before providing such services.

    c. Be responsive to incoming calls or other outreach from Members; maintain a phone line that is staffed or able to record voicemail twenty-four (24) hours a day, seven (7) days per week.

    d. Coordinate with other Providers in the Member's care team, including ECM Providers, other Community Supports Providers and CalOptima Health or the Health Network, as applicable.

    e. Comply with cultural competency and linguistic requirements in accordance with federal, State, and local laws, the Community Supports Provider's contract with CalOptima Health, and CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

f. Comply with applicable federal and State civil rights laws and shall not discriminate on the basis of any characteristic protected by federal and State nondiscrimination laws and in accordance with the Community Supports Provider's contract with CalOptima Health, and CalOptima Health Policy HH.1104: Complaints of Discrimination.

g. Coordinate with other entities to ensure the Member has access to appropriate supports, including, but not limited to Orange County Public Health, Orange County Behavioral Health Services and Social Services.

h. Support transition planning into other programs or services that meet the Member's needs when a CalOptima Health Community Support is discontinued for any reason.

i. Utilize best practices for Members experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

2. When federal law requires authorization for data sharing, Community Supports Providers shall obtain and document such authorization from each assigned Member, including sharing protected health information (PHI), and confirm it has obtained such authorization to CalOptima Health.

3. Community Supports Providers are encouraged to identify additional CalOptima Health Community Supports that may benefit a Member and send any additional request(s) for CalOptima Health Community Supports to CalOptima Health or the Member's Health Network, as applicable, for authorization.

H. Billing for Community Supports

1. For CalOptima Health and Health Network Members, except for Members enrolled in a Health Maintenance Organization (HMO) responsible for CalOptima Health Community Supports, a Community Supports Provider shall submit claims to CalOptima Health for CalOptima Health Community Supports services provided.

a. The claims shall be based on specifications from the DHCS-defined code sets and national standards.

b. All claims for Personal Care Services (PCS) and Home Health Care Services (HHCS) must be submitted with allowable Current Procedural Terminology or Healthcare Common Procedure Coding System (HCPCS) codes.

c. Community Supports Provider shall indicate the proper Place of Service or Revenue Code on claims and/encounters to indicate the rendering of Personal Care Services (PCS) and Home Health Care Services (HHCS) in a Member's home.

d. If the Community Supports Provider is unable to submit claims using such specifications, an invoice shall be submitted, with DHCS-defined minimum necessary data elements that support conversion of the invoice to a DHCS-defined specification and code set for submission to DHCS, including, but not limited to:

i. Member;

ii. CalOptima Health Community Supports services rendered; and

iii. Community Supports Provider.

I. A Community Supports Provider shall submit CalOptima Health Community Supports claims or invoices for a Member assigned to a Health Maintenance Organization (HMO) responsible for CalOptima Health Community Supports to the HMO for processing. Community Supports Provider Qualifications and Service Transition Criteria for existing and future CalOptima Health Covered Services: CalOptima Health Community Supports will be provided to Members by contracted Community Supports Providers in accordance with the following requirements based on CalOptima Health's current and future Board of Directors and DHCS-approved offerings:

1. Housing Transition Navigation Services

    a. Minimum Provider qualifications include:

        i. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

        ii. Strong relationships with local housing authorities;

        iii. Demonstrated local experience in the provision of Housing Transition Navigation Services, including housing-related services and supports; and

        iv. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

    b. Housing Transition Navigation Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until such time as the Member:

        i. Is successfully placed in permanent housing, and transitioned to Housing Tenancy and Sustaining Services, as appropriate;

        ii. Refuses Housing Transition Navigation Services;

        iii. Loses funding and/or a housing voucher, where no resolution of the loss exists;

        iv. Is no longer physically, cognitively, or emotionally able to reside in independent, supported housing; or

        v. Is no longer eligible with CalOptima Health or a Health Network.

    c. A Community Supports Provider shall provide Housing Transition Navigation Services at an appropriate frequency for the needs of the Member, considering the specific barriers that exist for that Member and shall ensure seamless service to Members entering Housing Transition Navigation Services.

2. Housing Deposits

    a. Minimum Provider qualifications include:

        i. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

ii. Strong relationships with local housing authorities;

iii. Demonstrated or verifiable experience in providing these unique services; and

iv. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

b. Housing Deposits, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until the Member:

i. Refuses Housing Transition Navigation Services (at a minimum, tenant screening, housing assessment and individualized housing support);

ii. Is no longer physically, cognitively or emotionally stable to reside in independent, supported housing; or

iii. Loses eligibility with CalOptima Health or a Health Network.

3. Housing Tenancy and Sustaining Services

a. Minimum Provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and requirements;

ii. Demonstrated or verifiable experience in providing housing-related services and supports; and

iii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policies GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

b. Housing Tenancy and Sustaining Services, as described in Attachment A of this Policy, are provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima Health or a Health Network until:

i. The Member's housing support plan determines they are no longer needed;

ii. The Member refuses Housing Tenancy and Sustaining Services;

iii. Loss of funding and/or housing voucher, where no resolution of the loss exists;

iv. The Member is no longer physically, cognitively or emotionally able to reside in independent, supported housing; or

v. The Member is no longer eligible with CalOptima Health or a Health Network.

4. Recuperative Care

    a. Minimum Provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing Recuperative Care;

        ii. Services are provided in compliance with the National Standards for Recuperative Care Programs; and

        iii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

    b. Recuperative Care, as described in Attachment A of this Policy, is provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima Health or a Health Network until:

        i. Services are no longer required for the Member, and a discharge plan has been established;

        ii. The Member has received ninety (90) continuous days of Recuperative Care;

        iii. The Member refuses Recuperative Care; or

        iv. The Member is no longer eligible with CalOptima Health or a Health Network.

    c. Presumptive authorization to ensure these services meet Member's urgent needs who may be harmed by a delay in authorization. Presumptive authorization will be valid for no longer than fourteen (14) days total from date of admission into the Recuperative Care facility.

        i. Formal authorization from CalOptima Health or a Health Network must be obtained for the Recuperative Care stay.

            a) The CalOptima Health Recuperative Care Provider is responsible for immediate submission of a request for Recuperative Care to CalOptima Health or a Health Network, including for those days presumptively authorized by the Recuperative Care Provider, the authorization request shall include:

                1) The request form and medical information including, but not limited to: discharge instructions, discharge summary, referral(s) for home health or durable medical equipment (DME), as appropriate, post-discharge medications and post discharge follow-up appointment provider, date and time.

5. Short-Term Post-Hospitalization Housing

    a. Minimum Provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing Short-Term post Hospitalization Housing for Members with high medical or behavioral health needs;

        ii. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

iii. Strong relationships with local housing authorities;

iv. Demonstrated or verifiable experience in providing these unique services; and

v. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

b. Short-Term Post-Hospitalization Housing, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

i. Services are no longer required for the Member, and a discharge plan has been established;

ii. The Member refuses Short-Term Post-Hospitalization Housing;

iii. The Member is no longer physically, cognitively or emotionally able to reside in independent, supported housing; or

iv. The Member is no longer eligible with CalOptima Health or a Health Network.

c. A Community Supports Provider shall provide Short-Term Post-Hospitalization Services at an appropriate frequency for the needs of the Member and not to exceed a six (6) month duration.

d. CalOptima Health and Health Networks will process expedited authorization requests for short-term post-hospitalization within seventy-two (72) hours.

6. Medically-Tailored Meals

a. Minimum Provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring

b. Medically-Tailored Meals, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

i. Services are no longer medically necessary or required for the Member;

ii. The Member refuses Medically-Tailored Meals Services;

iii. The Member has received medically-supportive food and nutrition services for 12 weeks or a maximum of 24 weeks if medically necessary; or

iv. The Member is no longer eligible with CalOptima Health or a Health Network.

c. CalOptima Health and Health Networks will process expedited authorization requests for medically tailored meals for post-acute care within seventy-two (72) hours of discharge.

7. Sobering Centers

a. Minimum Provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population;

ii. Established working relationships with County behavioral health agency;

iii. Strong relationships with law enforcement, emergency personnel, and community outreach partners to identify and divert individuals to Sobering Centers; and

iv. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

b. Sobering Centers, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

i. Services are no longer necessary or required for the Member;

ii. The duration of services received by the Member approaches the limit (less than twenty-four (24) hours); or

iii. The Member is no longer eligible with CalOptima Health or a Health Network.

c. CalOptima Health has an established process with CalOptima Health Sobering Center Providers for presumptive eligibility in order to ensure CalOptima Health Members receive services timely. Authorizations for sobering centers are for less than 24 hours.

8. Personal Care/Homemaker Services

a. Minimum Provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population; and

ii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

b. Personal Care/Homemaker Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Personal Care/Homemaker Services; or

iii. The Member is no longer eligible with CalOptima Health or a Health Network.

9. Day Habilitation Program

a. Minimum Provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services;

ii. Services are provided in compliance with the National Standards for Adult Day Service Programs; and

iii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

b. Day Habilitation Program, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Day Habilitation Program Services; or

iii. The Member is no longer eligible with CalOptima Health or a Health Network.

10. Respite Services

a. Minimum Provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

b. Respite Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member has reached the three hundred thirty-six (336) hour annual limit; or

iii. The Member is no longer eligible with CalOptima Health or a Health Network.

11. Nursing Facility Transition for Elderly and Adult Residential Facilities

    a. Minimum Provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing Nursing Facility services; and

        ii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

    b. Nursing Facility Transition for Elderly and Adult Residential Facilities, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

        i. Services are no longer required for the Member;

        ii. The Member refuses Nursing Facility Transition for Elderly and Adult Residential Facilities Services; or

        iii. The Member is no longer eligible with CalOptima Health or a Health Network.

12. Community Transition Services/Nursing Facility Transition to Home

    a. Minimum Provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing Community Transition Services/Nursing Facility Transition to Home services; and

        ii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring

    b. Community Transition Services/ Nursing Facility Transition to Home, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

        i. Services are no longer required for the Member;

        ii. The Member refuses Community Transition Services/ Nursing Facility Transition to Home Services;

        iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

        iv. The Member is no longer eligible with CalOptima Health or a Health Network.

13. Environmental Accessibility Adaptations

    a. Minimum Provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing Environmental Accessibility Adaptations

        ii. Services are provided in compliance with applicable State and local building codes; and

        iii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight, and HH.2021: Exclusion and Preclusion Monitoring.

    b. Environmental Accessibility Adaptations, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

        i. Services are no longer required for the Member;

        ii. The Member refuses Environmental Accessibility Adaptations

        iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

        iv. The Member is no longer eligible with CalOptima Health or a Health Network.

    c. The assessment and authorization for Environmentally Accessibility Adaptations (EAA) will take place within a ninety (90) day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

14. Asthma Remediation

    a. Minimum Provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing Asthma Remediation services;

        ii. Services are provided in compliance with applicable State and local building codes; and

        iii. Successful completion of CalOptima Health's pre-contractual review in accordance with CalOptima Health Policy GG.1619: Delegation Oversight and HH.2021: Exclusion and Preclusion Monitoring.

    b. Asthma Remediation, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima Health or a Health Network until:

        i. Services are no longer required for the Member;

        ii. The Member refuses Asthma Remediation services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima Health or a Health Network.

J. CalOptima Health or a Health Network shall track referrals to a Community Supports Provider to verify that authorized services have been initiated for the Member.

K. CalOptima Health or a Health Network will receive regular updates from the Community Supports Provider about the Member's progress toward goals, changes in status or barriers and other significant information affecting CalOptima Health Community Supports for the Member.

1. A Health Network shall provide data to CalOptima Health about the ongoing monitoring of appropriate and timely delivery of CalOptima Health Community Supports to their Members in a manner and format defined by CalOptima Health and in accordance with CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting.

L. CalOptima Health shall ensure timely and accurate processing of claims for CalOptima Health Community Supports in accordance with applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance and CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible.

M. Oversight of CalOptima Health Community Supports

1. CalOptima Health shall perform oversight of Community Supports Providers and hold Community Supports Providers accountable for all regulatory and contractual requirements, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

a. CalOptima Health shall hold Community Supports Providers responsible for the same reporting requirements as those that CalOptima Health must report to DHCS.

b. CalOptima Health will not impose upon the Community Supports Providers mandatory reporting requirements that are different from or in addition to those required for encounter and supplemental reporting.

2. CalOptima Health may subcontract with other entities to administer CalOptima Health Community Supports, and must comply with all of the following:

a. CalOptima Health will maintain and be responsible for compliance oversight of all contract provisions and covered services, regardless of the number of subcontracting layers.

i. Subcontractor agreements will mirror the DHCS ECM and CalOptima Health Community Supports contract template requirements and the ECM and Community Supports Provider Standard Terms and Conditions.

b. CalOptima Health shall retain responsibility for development and maintenance of DHCS-approved policies and procedures to ensure that subcontractors meet required responsibilities and functions.

c. CalOptima Health shall be responsible for evaluating prospective subcontractor's ability to perform services.

d. CalOptima Health is responsible for ensuring that subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members.

e. CalOptima Health will report to the DHCS the names of all subcontractors by type and service(s) provided and identify Orange County as the county in which Members are served.

i. CalOptima Health will make all subcontractor agreements available to DHCS upon request. Such agreements must contain the minimum required information specified by DHCS, including method and amount of compensation.

3. On a quarterly basis, CalOptima Health shall review CalOptima Health Community Supports authorizations to ensure equitable and non-discriminatory approval determinations.

a. CalOptima Health will evaluate the ethnic and racial characteristics of the population for whom CalOptima Health Community Supports is requested against the same characteristics of the population that was authorized for CalOptima Health Community Supports and provide feedback on the assessment. If CalOptima Health identifies an inequitable effect, CalOptima Health will refer the issue to the Audit and Oversight Department for continued action, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

b. CalOptima Health shall monitor healthcare service utilization and outcomes of Member populations receiving CalOptima Health Community Supports as follows:

i. On a monthly basis, CalOptima Health shall monitor the housing status and program participation for each Member receiving housing-related CalOptima Health Community Supports.

ii. On a semi-annual basis, CalOptima Health shall monitor emergency room visits and hospitalizations for Members receiving Recuperative Care and analyze utilization prior to and after initiation of services.

N. CalOptima Health shall submit the following data and reports in a manner, format and frequency as defined by DHCS:

1. Encounter data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS, including services generated under subcontracting arrangements.

2. Data will be provided to:

a. Evaluate the utilization and effectiveness of a Community Support;

b. Monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken; and

c. Monitor Member appeals and grievances associated with Community Supports.

3. Supplemental reports, on a schedule and in a format as specified by DHCS.

IV. ATTACHMENT(S)

A. Community Supports Components
B. Community Supports Eligibility (Population Subset)

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
B. Department of Health Care Services (DHCS) Managed Care CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS) Contract Template Provisions
C. CalAIM Community Supports Model of Care Template (June 2024)
D. Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide (July 2023)
E. CalOptima Health Contract for Health Care Services
F. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
G. CalOptima Health Policy EE.1103: Provider Network Training
H. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
I. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
J. CalOptima Health Policy GA.7110: Street Medicine
K. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
L. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
M. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management (ECM) Service Delivery
N. CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management (ECM) Administration
O. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
P. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.
Q. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
R. CalOptima Health Policies GG.1619: Delegation Oversight
S. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
T. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
U. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
V. CalOptima Health Policy HH.1102: Member Grievance
W. CalOptima Health Policy HH.1104: Complaints of Discrimination
X. CalOptima Health Policy HH.1108: State Hearing Process and Procedures
Y. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
Z. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
AA. CalOptima Health Policy MA.6021a: Continuity of Care for New Members
BB. CalOptima Health Policy MA.9002: Enrollee Grievance Process
CC. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
DD. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
EE. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
FF. Department of Health Care Services (DHCS) 2024 Medi-Cal Managed Care Plan Transition Policy Guide, Version 7 – March 22, 2024
GG. Department of Health Care Services (DHCS) CalAIM D-SNP Policy Guide
HH. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements
II. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004)
JJ. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-018: Managed Care Health Plan Transition Policy Guide

KK. 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)
LL. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/30/2021	Department of Health Care Services (DHCS)	Approved as Submitted
12/02/2022	Department of Health Care Services (DHCS)	Approved as Submitted
12/13/2022	Department of Health Care Services (DHCS)	Approved as Submitted
12/29/2022	Department of Health Care Services (DHCS)	Approved as Submitted
04/21/2023	Department of Health Care Services (DHCS)	File & Use
11/16/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1355	Community Supports	Medi-Cal
Revised	01/01/2023	GG.1355	CalAIM Community Supports	Medi-Cal OneCare
Revised	04/01/2023	GG.1355	CalAIM Community Supports	Medi-Cal OneCare
Revised	06/01/2023	GG.1355	CalAIM Community Supports	Medi-Cal OneCare
Revised	10/01/2023	GG.1355	CalAIM Community Supports	Medi-Cal OneCare
Revised	09/01/2024	GG.1355	CalAIM Community Supports	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
California Medicaid State Plan	A comprehensive description of California's State Medicaid Program, based upon the requirements of Title XIX of the Social Security Act, that serves as a contractual agreement between the State of California and the federal Centers for Medicare and Medicaid Services.
CalOptima Health Community Supports	Community Supports that CalOptima Health has received approval from the Department of Health Care Services (DHCS) to provide.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Community Health Worker Services (CHW)	Preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified in CalOptima Health's contract with the Department of Health Care Services (DHCS) for Medi-Cal.
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

Term	Definition
Community Supports Provider	Entities that CalOptima Health has determined can provide Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in the DHCS Contract.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Covered Services	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: 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);

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

Term	Definition
Department of Health Care Services (DHCS)	Medi-Cal: The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Enhanced Care Management (ECM) Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Health Direct.
Enhanced Care Management (ECM) Provider	Community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for Enhanced Care Management (ECM).
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
Electronic Visit Verification (EVV)	EVV is a federally mandated telephone and computer-based application program that electronically verifies in-home service visits.

Term	Definition
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
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.

Term	Definition
Member	Medi-Cal: 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. OneCare: A beneficiary enrolled in a CalOptima Health OneCare program.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. 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.
Recuperative Care	Short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.
Street Medicine	A set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. The fundamental approach of Street Medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Street Medicine utilizes a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address Social Drivers of Health that impede health care access.