Policy:	EE.1141
Title:	**CalOptima Health Provider Contracts**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 02/21/2025*
Effective Date:	02/01/2017
Revised Date:	02/01/2025
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This Policy establishes the process by which CalOptima Health contracts with Providers or establishes Letters of Agreement (LOAs), as appropriate with out-of-network Providers, to meet its State and Federal obligations regarding Network adequacy and Continuity of Care.

II. POLICY

A. CalOptima Health may enter into a contract for participation directly with a Provider to ensure access to Covered Services for Members.

B. CalOptima Health may contract with Providers that meet the participation requirements for applicable health care programs and are fully Credentialed by CalOptima Health in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners, and GG.1651: Assessment and Re-Assessment of Organizational Providers.

1. As a condition of contracting for the CalOptima Health Medi-Cal and CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) programs, Providers:

   a. Must be enrolled in the State's Medi-Cal Program in accordance with the requirements set forth by the Department of Health Care Services (DHCS) and applicable All Plan Letters (APLs). Providers must also be enrolled in the State's Medi-Cal Program as a condition of providing Medi-Cal wrap around services not covered under the OneCare Medicare program.

   b. Must not be excluded from participation in, be suspended by, or have opted out of Medicare, nor be listed on the Centers for Medicare & Medicaid Services (CMS) Preclusion List, as provided in CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

2. Providers whose Medi-Cal enrollment is pending DHCS approval, CalOptima Health may extend a Provisional LOA for one hundred twenty (120) calendar days, allowing them to participate in a Network while their Medi-Cal application undergoes review, in accordance with DHCS APL-22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.

a. Should a Provider not receive Medi-Cal approval during the one hundred twenty (120) days, CalOptima Health will not re-initiate a contract with the Provider during the period in which the Provider re-submits its Medi-Cal enrollment application.

C. CalOptima Health shall determine Network adequacy by health care program and contract with those Provider types needed to, at a minimum, maintain an adequate Network as described in the requirements of each program. If CalOptima Health determines there is an unmet Provider coverage need which causes Member access issues and/or unmet Continuity of Care obligations, the CalOptima Health Contract Manager shall reach out to Providers, identified and through claims paid data, LOAs, Letters of Interest, or Member requests, and invite them to contract with CalOptima Health.

1. Network adequacy for the CalOptima Health Medi-Cal program shall include contracting for Managed Long Term Care Services and Supports (MLTSS) pursuant to DHCS requirements, and in accordance with CalOptima Health Policy EE.1135: Long-Term Care Facilities (LTCs) Contracting Requirements.

D. CalOptima Health shall use provider contract templates as approved by the CalOptima Health Board of Directors and DHCS based on Provider type. If necessary, CalOptima Health may contract for services at a rate that exceed levels approved by the CalOptima Health Board of Directors.

E. CalOptima Health shall execute a Single Case Agreement LOA with an out-of-network Provider where Medically Necessary, Covered Services to a Member are required as follows:

1. In order to access care not available through contracted Providers and where the Providers of the necessary services do not accept CalOptima Health's Non-Contracted Provider rates;

2. In order to meet network adequacy requirements in accordance with CalOptima Health policies effective at the time;

3. For Continuity of Care needs where the Provider will accept CalOptima Health's Board-approved contract rates, but does not wish to be a directly contracted CalOptima Health Provider; or

4. For Continuity of Care needs when the Provider will not accept CalOptima Health's Non-Contracted Provider rates, but transitioning the care to a contracted Provider:

a. Would require the Member to receive services from multiple Providers/facilities in an uncoordinated manner which would significantly impact the Member's condition; or

b. Could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or

c. Would require Member to undertake a substantial change in recommended treatment for Medically Necessary, Covered Services.

F. CalOptima Health shall comply with all applicable provisions of the DHCS All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, including any subsequent guidance, and the laws referenced therein.

G. CalOptima Health shall not, by use of an exclusive provision, clause, agreement, or in any other manner, prohibit any Network Provider from providing services to Medi-Cal Members who are not

a Member of CalOptima Health. This prohibition is not applicable to contracts entered into between CalOptima Health and Knox-Keene licensed health care service plans.

III. PROCEDURE

A. Preliminary Evaluation

1. Providers who wish to contract with CalOptima Health's Medi-Cal program must be actively enrolled with Medi-Cal, for their National Provider Identifier (NPI) Type 1 and Type 2, as applicable. CalOptima Health procedures for verifying and screening Medi-Cal Provider enrollment, shall be conducted in accordance with CalOptima Health Policies GG.1650: Credentialing and Re-credentialing of Practitioners and GG.1651: Assessment and Reassessment of Organization Providers.

2. Physicians shall be required to meet the minimum physician standards as described in CalOptima Health Policy GG.1643: Minimum Physician Credentialing Standards and must complete a Credentialing application. The CalOptima Health Quality Improvement Department shall review and approve or deny the Credentialing application in accordance with CalOptima Health Policies GG.1643: Minimum Physician Credentialing Standards, and GG.1650: Credentialing and Recredentialing of Practitioners.

3. Health Delivery Organizations (HDOs) shall be required to complete a Credentialing application. The CalOptima Health Quality Improvement Department shall review and approve or deny the Credentialing application in accordance with CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers.

4. The Quality Improvement Department shall notify the Contracting and Provider Relations Departments when a Provider has been approved or denied Credentialing requirements.

5. If CalOptima Health denies Provider Credentialing, the following contractual-related notices shall be sent to the Provider after the Quality Improvement Department has notified the Provider of the credentialing denial:

    a. Contracting Department: Contracting shall notify the Provider that CalOptima Health will not be able to contract with the Provider.

    b. Provider Relations Department: If Credentialing has been denied for a new physician who is a provider in an existing CalOptima Health contracted physician group, the Provider Relations Department shall notify the contracted physician group that CalOptima Health will not be able to include the physician under the group contract.

B. Provisional LOA

1. For Providers who demonstrate Medi-Cal registration is pending with DHCS, proof of completed submission will be accepted in lieu of enrollment status.

2. The Contracting Department will prepare and send a Provisional LOA that is valid for one hundred twenty (120) calendar days.

    a. The Contracting Department may extend the LOA for an additional sixty (60) calendar days, not to exceed one hundred eighty (180) days, to allow completion of the Medi-Cal enrollment process with DHCS.

3. Credentialing will communicate final status of Medi-Cal registration and credentialing, notifying the Contracting Department with the following Medi-Cal Registration and credentialing status:

    a. Completed: the Contracting Department will replace the Provider's Provisional LOA with a full contract upon notification from Credentialing, and notify the Provider; or

    b. Unsuccessful: the Contracting Department will terminate the one hundred twenty (120) calendar day Provisional LOA upon notification from Credentialing.

        i. In instances of an unsuccessful Medi-Cal enrollment, the Provisional LOA will be terminated no later than fifteen (15) calendar days from DHCS' date of notification to the Provider.

        ii. Re-initiation of the contract will only occur following provider notification to CalOptima Health of successful Medi-Cal enrollment.

C. Single Case Agreement LOA

1. CalOptima Health shall arrange for Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima Health is unable to provide services in the contracted Network, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals, or when it is necessary for purposes of Continuity of Care, in accordance with APL 23-022: Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members who Transition into a New Medi-Cal Managed Health Plan on or After January 1, 2023 and Health and Safety Code, Section 1373.96.

2. Upon receipt of a completed LOA Request Form from CalOptima Health's Utilization Management, Long Term Services and Support (LTSS), Behavioral Health, or PACE departments, approved by the Medical Director, or assigned Designee, CalOptima Health Contracting shall generate an LOA for:

    a. Medi-Cal: Out-of-network hospitals, physicians, ancillary, or other entities, as necessary, that do not accept CalOptima Health's Non-Contracted Provider rates as specified in CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible.

        i. If CalOptima Health has a DHCS-approved Alternative Access Standard for a Core Specialist(s), the LOA shall be offered to the Core Specialist(s) at no less than the Medi-Cal FFS rate, be agreed upon by CalOptima Health and the Provider, and must be made within the most recent year.

    b. Medicare: Out-of-network OneCare, and PACE Providers that do not accept CalOptima Health's Non-Contracted Provider rates for these Medicare programs.

    c. LTC: All Medi-Cal out-of-network long-term care facilities.

    d. Whole Child Model (WCM): In accordance with DHCS APL 24-015: California Children's Service Whole Child Model Program, Inter-County Transfer CalOptima Health may need to enter into a one-time payment agreement with the Providers in the receiving county.

3. CalOptima Health may enter into an LOA with a Provider that is not enrolled in the State's Medi-Cal program if the Provider is needed for Continuity of care referrals or for access to care that is not available through CalOptima Health's contracted Provider network.

4. Once the LOA is fully executed, the Contracting Department shall send a notification of the completed LOA to internal departments, as applicable. The notification of a signed LOA is only for internal departments who have additional processes related to implementation.

D. Contract Completion

1. Upon notification from the Quality Improvement Department that a Provider's credentialing application has been approved, the Provider's contract shall be processed as follows:

   a. The Contracting Department shall offer the Provider a contract including program-based rates within approved limits set by the CalOptima Health Board of Directors.

   b. Providers shall be required to complete and return the Ownership and Control Disclosure form for inclusion in the contract, in accordance with DHCS APL 23-006: Delegation and Subcontractor Network Certification:

      i. Ensure the Contracted Provider completes all the required information, for each person with an ownership or control interest and for each managing employee.

      ii. Review to identify potential conflicts of interest. Alert Regulatory Affairs & Compliance (RAC) upon discovery of any conflict(s) of interest. The RAC Department has ten (10) business days, upon notification from the Contracting Department of the noncompliant Contracted Provider, to notify DHCS of the Contracted Provider's noncompliance.

   c. The Contract will be signed by the Provider and returned to CalOptima Health Contracting Department.

   d. The Contracting Department shall route the partially executed contract to the appropriate CalOptima Health signature authority for counter-signature in accordance with the CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

2. Once the contract is fully executed, the Contracting Department shall complete and forward a contract summary form to internal departments, as applicable. The Contract Summary is notice of a signed agreement only for internal departments who have additional processes related to implementation.

3. The Contracting Department shall assign the effective date as the first day of the month following the signature of both parties, unless:

   a. An effective date is specified in an applicable CalOptima Health Board Action Agenda Referral (COBAR); or

   b. Additional time is required for information systems programming.

4. Provider Relations: If a newly Credentialed physician is part of an existing contracted physician group, the Provider Relations Department shall assign the effective date as the first day of the month following approval notification from the Quality Improvement Department. The Provider

Relations Department shall notify the Provider Data Operations Department to enter the physician into the CalOptima Health system of record (FACETS).

5. The Contracting Department shall notify the Provider of contract completion and forward the fully executed contract to the Provider.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicaid & Medicare Services (CMS) for OneCare
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy EE.1135: Long-Term Care Facilities (LTCFs) Contracting Requirements
E. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
F. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority
G. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Health Policy GG.1643: Minimum Physician Credentialing Standards
I. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
J. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
K. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised August 24, 2022)
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements (Supersedes APL 21-006)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (Supersedes APL 22-032)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
P. Department of Health and Human Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
R. Health and Safety Code, section 1373.96

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/22/2023	Department of Health Care Services (DHCS)	File and Use
06/13/2024	Department of Health Care Services (DHCS)	File and Use
08/06/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/05/2007	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
04/04/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2017	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	04/04/2019	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2020	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2022	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	02/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	04/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	05/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	12/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	08/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	12/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	02/01/2025	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
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.
Core Specialist	Adult and pediatric providers as specified in Department of Health Care Services All-Plan Letter 20-003: Network Certification Requirements, including Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, and Pulmonology.
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.

Term	Definition
	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 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;

Term	Definition
	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 Centers of Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima Health PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Credentialing	Medi-Cal & OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
Department of Health Care Services (DHCS)	Medi-Cal & OneCare: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. PACE: The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Letter of Interest	A letter received by CalOptima Health from an entity that is interested in contracting with CalOptima Health to provide services covered under one or more CalOptima Health Programs.
Medically Necessary	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)

Term	Definition
	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 include 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.
Member	A beneficiary enrolled in a CalOptima Health program.
Network	Primary Care Providers, Specialists, hospitals, pharmacy, ancillary Providers, facilities, and any other Providers that subcontract with CalOptima Health for the delivery of Covered Services.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member.
Preclusion List	CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
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.
Provisional Letter of Agreement (LOA)	Provider must demonstrate they are Medi-Cal enrolled or in the process of being enrolled. Provider has initiated the CalOptima Health credentialing process. Provider may actively provide services to Members under qualifying for Continuity of Care, as applicable, upon receiving authorization from the Utilization Management (UM) department. Valid for 120 days from effective date, and may be used for multiple Members.
Single Case Agreement Letter of Agreement (LOA)	Services must be prior authorized by the UM department. Authorization number and contracted services must be defined on the LOA. Valid for one (1) year from the UM date, and is a one-time agreement for a single Member.