Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/ Michael Hunn 10/17/2024*
Effective Date:	06/01/2017
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines an Organizational Provider's (OPs), or a Provider rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or other Delegate. If CalOptima Health chooses to delegate this function, the follow shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit P&Ps that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

C. CalOptima Health may delegate the assessment and Reassessment of OPs to a Health Network in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to assess and reassess OPs to participate in its CalOptima Health programs that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and shall actively participate in the assessment and Reassessment of an OP.

E. The CalOptima Health Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network.

F. CalOptima Health shall assess or reassess OPs including, but not limited to:

1. Acute Rehabilitation Facilitates;
2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
3. Birthing Centers;
4. Certified Hospice Providers/ Home Health Agencies;
5. Chronic Dialysis Clinic;
6. Outpatient Clinical Laboratory;
7. Community Based Adult Services (CBAS) Providers;
8. Community Clinic;
9. Dialysis Center;
10. Durable Medical Equipment (DME) Providers;
11. Federally Qualified Health Clinic;
12. Free Clinic;
13. Health Access Program;
14. Hospitals;
15. Medical and Non-Medical Ground Transportation;
    i. For Transportation Network Companies (TNC), CalOptima Health is not responsible for credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.
16. Non-Emergency Medical Transportation;
17. Rehabilitation Clinic;
18. Residential Care Facilities for the Elderly;

19. Rural Health Clinic;

20. Skilled Nursing Facilities/Long Term Care Facility;

21. Free Standing Surgical Center;

22. Free Standing Urgent Care Center;

23. Free Standing Radiology Center;

24. Transplant Programs;

25. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD); and

26. Indian Health Care Providers or Facilities

G. CalOptima Health shall ensure that any Provider for whose provider type has an enrollment pathway with DHCS, including ordering, referring and prescribing (ORP) Providers, is screened and enrolled with DHCS as a Provider in accordance with DHCS APL 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described in Sections III.A. and III.B. of this Policy.

1. State-level enrollment pathways are available either through the Department of Health Care Services' (DHCS) Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health shall have the option to develop and implement a managed care Provider screening and enrollment process that meets the requirements of this APL, or CalOptima Health direct Network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers not having a corresponding state-level enrollment pathway, including but not limited to community supports Providers (e.g., housing agencies, medically tailored meal), and Applied Behavioral Analysis (ABA) Providers, Enhanced Care Management (ECM) are not required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific Community Supports for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

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

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

5. History of liability claims against the Provider.

I. CalOptima Health may allow Providers to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' Provider Enrolment Division (PED) or an DHCS approved screening and enrollment process.

1. CalOptima Health shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before terminating.

J. CalOptima Health shall require that the OP be successfully assessed, including confirmation that the OP is in good standing with state and federal regulatory agencies, prior to contracting and every three (3) years thereafter.

K. CalOptima Health shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this Policy if the Provider is not accredited, as applicable.

L. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health shall confirm the Medi-Cal and Medicare participation status of the OP.

M. If CalOptima Health declines to include an OP in the CalOptima Health Provider network, CalOptima Health shall notify, in writing, such OP within sixty (60) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

N. CalOptima Health shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1604: Confidentiality of Credentialing Files.

III. PROCEDURE

A. Provider Screening and Enrollment

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider screening and enrollment process does not need to be completed by CalOptima Health.

3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, then the CalOptima Health may complete screening and enrollment established by CalOptima Health.

a. CalOptima Health shall notify DHCS and submit its policies and procedures (P&Ps) for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all provider types.

b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a Provider application (while state law allows DHCS up to one hundred eighty (180) calendar days to act on an enrollment application if the Provider applies directly to DHCS).

c. CalOptima Health shall submit a list of its newly enrolled Providers to DHCS every six months to their DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each Provider type and ensure that the application is reviewed for both accuracy and completeness.

    i. CalOptima Health shall inform their Network Providers, as well as any Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Provider's right to enroll through DHCS, at the time of application and must include, but is not limited to the following elements:

        a) A statement that certain enrollment functions will not be performed by CalOptima Health, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

        b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider chooses to enroll through CalOptima Health, including provisional Provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an CalOptima Health's decision to suspend the enrollment process.

        c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

        d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

    ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS application fee amount.

    iii. CalOptima Health shall obtain the Provider's consent in order to share information relating to the Provider's application and eligibility with DHCS.

    iv. CalOptima Health shall collect and maintain the original signed a Medi-Cal Provider Agreement and Network Provider Agreement for each Provider.

v. CalOptima Health shall maintain all Provider enrollment documentation in a secure manner to ensure confidentiality of Provider's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42, CFR, Section 455.104 through the Alliance Key Disclosure form.

i. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health request, a Network Provider must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any Subcontractor with whom the Network Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the 12-month period ending on the date of the request; and,

b) Any significant business transactions between the Network Provider and any wholly owned supplier, or between the Provider and any Subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial Provider applications, including applications for a new practice location, and any applications received in response to a Network Provider's reenrollment or revalidation request to determine the Provider's categorical risk level as limited, moderate, or high.

i. If a Provider fits within more than one risk level, CalOptima Health must screen the Provider at the highest risk level.

ii. A Provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated Provider lists, and criminal background checks.

iii. CalOptima Health shall not enroll a Provider who fails to comply with the screening criteria for that Provider's assigned level of risk.

g. Providers are subject to screening based on verification of the following requirements:

i. Limited-Risk Providers:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Providers

a) Screening requirements of limited-risk Providers; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Providers:

a) Screening requirements of medium-risk Providers; and

b) Criminal background checks based in part on a set of fingerprints

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a Provider based on a credible allegation(s) of fraud, waste, or abuse.

ii. The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.

iii. The Provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The Provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.

i. Additional criteria for high-risk Providers

i. Any person with a 5% or more direct or indirect ownership in a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High-Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street MS 2200
Contact Name	MCMC

Field	Entry
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.

iv. The Provider must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a Provider that has been designated as high-risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the Provider's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk Providers to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Network Providers at least every five (5) years, and their high-risk Network Providers every three years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if Providers are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons including, but not limited to, the following:

a) The Provider was temporarily suspended from the Medi-Cal program;

b) The Provider's license was previously suspended;

c) There is conflicting information in the Provider's enrollment application;

d) There is conflicting information in the Provider's supporting enrollment documentation; and

e) As part of the Provider enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all Providers:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted Providers continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

iii. Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's Provider network.

l. If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for further enrollment options.

m. If the CalOptima Health acquires information, either before or after enrollment that may impact the Provider's eligibility to participate in the Medi-Cal program, or a Provider refuses to submit to the required screening activities, CalOptima Health may decline to accept that Provider's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. At the time of application, CalOptima Health shall inform network Providers, as well any Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Providers right to enroll with DHCS.

i. The Provider enrollment disclosure must include, but is not limited to, the following elements:

a) A statement that certain enrollment functions will not be performed by CalOptima Health, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider chooses to enroll through CalOptima Health including provisional Provider status with Medi-Cal

FFS, processing timelines of the enrollment application, and the ability to appeal an CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

q. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

r. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up to date.

s. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.

t. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

B. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.C. of this Policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

a. OPs shall include a roster, a list of practitioners associated with the OP, where applicable, as part of the application;

b. OPs shall ensure that all information included in assessment application is no more than six (6) months old;

i. CalOptima Health shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

ii. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

iii. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is in compliance with any other applicable state or federal requirements and possesses a business license (or business tax certificate), as applicable.

d. Accreditation and/or Government Issued Certification, as applicable.

i. The Joint Commission (TJC): A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. Durable Medical Equipment (DME) or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, Durable Medical Equipment prosthetics orthotic suppliers, pharmacies;

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of End State Renal Disease Facilities; and

xiv. The California Department of Public Health (CDPH) for Hospitals, Ambulatory Surgery Centers, Home Health Agencies, Hospices, Dialysis Centers, Community Based Adult Services (CBAS), Skilled Nursing Facilities, Federal Qualified Health Centers (FQHC) verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a quality review by the state, CMS, or similar agency in lieu of a site visit.

a) The State, CMS, or a similar agency, quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. A copy of any history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare and/or Medi-Cal, as applicable;

h. A copy of the PED Certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with California Children's Services (CCS) Program if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free-Standing Urgent Care centers providing services to CalOptima Health Members pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. CalOptima Health shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

6. Additional Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD):

a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.B.2. of this Policy.

b. A signed ICF/DD Attestation, in accordance with DHCS APL 23-023: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care Section XII, under penalty of perjury attesting that the following Credentialing requirements are satisfied and include

i. Completion of the CalOptima Health Provider training within the last two (2) years;

ii. A Facility Site Audit from a State Agency;

iii. No change in five percent (5%) Ownership Disclosure;

iv. Possession of an active CDPH License and CMS Certification; and

v. In good standing as a Regional Center Vendor.

c. W-9 Request for Taxpayer Identification Number and Certification.

d. City or County Business License (excluding ICF/DD-H and N homes with six (6) or less residents)

e. Certificate of Insurance for Professional and General Liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

C. OP Reassessment

1. CalOptima Health shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

a. Collect and/or verify, at a minimum, all of the information required for initial assessment, as set forth in Section III.A. of this Policy;

b. Incorporate the following data in the decision-making process:

i. Quality review activities, including but not limited to, information from:

a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, Potential Quality Issue (PQI) cases, and Compliance cases, as applicable;

c) Review of Facility Site Review (FSR) or Physical Accessibility Review Survey (PARS) results, as applicable; and

d) Review of Medical Records, as applicable.

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. Reassess ICF/DDs every two (2) years through re-submission of the requirements in Section III.B. of this Policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima Health's CPRC shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health programs through the peer review process, as necessary.

2. Completed OP files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment has occurred, and confirmation that the OP is in good standing with state and federal regulatory agencies.

i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve an OP's assessment and Reassessment file, and deem the file clean.

ii. Clean file lists approved by a medical director shall be presented at the CPRC for final approval and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration of information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

3. Provider files identified as not meeting credentialing criteria with exceptions or potential exceptions shall be referred to the Chief Medical Officer (CMO), Chair of the CPRC or designee for review.

    a. The CMO, Chair of the CPRC or designee shall review each file for Providers who do not meet credentialing criteria and make recommendations regarding approving or denying credentialing of the Provider to the CPRC. For Provider files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO, Chair of the CPRC or designee.

4. The CPRC shall make recommendations on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this Policy.

    a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter, within sixty (60) calendar days of the decision indicating:

        i. Acceptance; or

        ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

5. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

IV. ATTACHMENT(S)

A. Organizational Provider Application

V. REFERENCE(S)

A. California Evidence Code, §1157
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Policy GG.1355: CalAIM Community Supports
G. CalOptima Health Policy GG.1604: Confidentiality of Credentialing Files
H. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
I. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
J. CalOptima Health Policy GG.1608: Full Scope Site Reviews
K. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
L. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)

N. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-034: California Children's Services Whole Child Model Program (Supersedes APL 21-005)
Q. Department of Health Care 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)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
T. Title 42, United States Code, §1320a-7(a)
U. Title 45, Code of Federal Regulations, Part 455
V. Title XVIII and XIV of the Social Security Act
W. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
X. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE

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. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
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.
Credentialing	Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider 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.
Credentialing Peer Review Committee	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
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.

Term	Definition
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume Specialty Care Provider offices.
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. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 18 CFR Section 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that health network.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	A beneficiary enrolled in a CalOptima Health program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient

Term	Definition
	rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
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) 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.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with Developmental Disabilities and their families.