Policy:	EE.1101
Title:	**Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/ Michael Hunn 12/05/2024*
Effective Date:	11/01/1995
Revised Date:	12/05/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for adding, changing, or terminating a Provider in the CalOptima Health Provider Directory and Web-based Directory.

II. POLICY

A. For each CalOptima Health program, CalOptima Health shall publish a printed hardcopy and online PDF version of the Provider Directory on a monthly basis, and a Web-based Directory that is updated within forty-eight (48) hours of an Addition, Change, or Termination of a Provider.

B. The Provider Directory shall include information on Health Networks, hospitals, Primary Care Providers (PCPs), OB/GYNs, specialists, behavioral health Providers, managed long-term services and support (MLTSS) Providers, urgent care centers, ancillary Providers, Facilities, and pharmacies who are credentialed and contracted with CalOptima Health directly or through a subcontracted agreement with a Health Network.

C. CalOptima Health shall ensure the printed hardcopy and online PDF version of the Provider Directory address Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) requirements for Provider Directories.

D. CalOptima Health shall submit the Medi-Cal Provider Directory to DHCS every six (6) months and shall include a PDF with the submission which DHCS can use for distribution, as needed.

1. CalOptima Health shall submit the Medi-Cal Provider Directory to DHCS on a monthly basis.

2. CalOptima Health shall address any findings during DHCS' Provider Directory reviews or medial audits within the timeframe specified by DHCS.

E. CalOptima Health shall update the Medi-Cal Provider Directory Application Programming Interface (API) in accordance with 42 CFR section 438.10(h)(3) and Health and Safety Code section 1367.27 and as outlined in Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule.

1. CalOptima Health and Health Networks shall conduct routine testing, monitoring, and system updates to ensure APIs function properly.

2. CalOptima Health and Health Networks shall attest to meeting all Provider Directory API requirements and shall submit attestation as outlined in Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule.

3. CalOptima Health and Health Networks shall reserve the right to deny or discontinue any third-party application's connections to an API if it is reasonably determined, consistent with the security risk analysis under the HIPAA Security Rule, that continued access presents an unacceptable risk to the security of PHI on CalOptima Health's systems.

    a. CalOptima Health's determination to deny or discontinue any third-party application's connection to an API shall be made using objective verifiable criteria that is applied fairly and consistently across all applications and developers.

4. CalOptima Health and Health Networks shall demonstrate to DHCS their ability to comply with interoperability requirements by submitting readiness, implementation and ongoing deliverables as directed by DHCS.

F. CalOptima Health and Health Networks shall report changes to information for a Provider or Facility in the CalOptima Health Provider Directory and Web-based Directory on an ongoing basis in accordance with this Policy.

G. CalOptima Health, Health Networks, Delegated Provider Groups, and Providers shall validate their directory information on a semi-annual basis in accordance with this Policy.

H. CalOptima Health shall require its contracted Providers be enrolled as Medi-Cal Providers, in accordance with DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment if there exists a state-level enrollment pathway.

I. CalOptima Health shall ensure the Web-based Provider Directory is made available in a machine-readable file and format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.

III. PROCEDURE

A. CalOptima Health shall publish a Provider Directory for each CalOptima Health program and a Web-based Directory that includes, but is not limited to, the following information to help existing and prospective Members choose physicians:

1. Headers to indicate city or region names (in alphabetical order);

2. Name;

3. Gender;

4. Specialty;

5. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

6. Area of focus, if applicable;

7. National Provider Identifier (NPI);
8. Hospital affiliation(s);
9. Primary care clinic or Medical Group affiliations, if applicable;
10. Board certification, if applicable;
11. Age limits (Member age minimum, Member age maximum, gender restrictions);
12. Listing of languages spoken by the Provider, including American Sign Language;
13. Listing of languages spoken by clinical staff;
14. Telehealth Provider indicators:
    a. Only Telehealth;
    b. No Telehealth (only in-person); or
    c. Both Telehealth and in-person;
15. Telehealth site indicators:
    a. Only Telehealth;
    b. No Telehealth (only in-person); or
    c. Both Telehealth and in-person;
16. Practice address (including suite number);
17. City;
18. State;
19. Zip code;
20. Telephone number including area code;
21. Proximity to public transportation;
22. After-hours telephone number;
23. Office days and hours;
24. California license number and type of license;
25. Web site URL, if applicable;
26. Public email address, if available and attestation is obtained;

27. Administrative email address;

28. Facility physical accessibility compliance (OSHA);

29. Provider type;

30. CalOptima Health program(s) (Medi-Cal and/or Medicare);

31. Tier, if applicable;

32. Health Network affiliation;

33. Facility affiliations (hospital name);

34. Hospital admitting privileges;

35. An individual Provider's panel status is at least one (1) of the following:

    a. Accepting new Members;

    b. Accepting existing Members;

    c. Available by referral only;

    d. Available only through a hospital or Facility;

    e. Not accepting new patients; or

    f. Accepting new and existing patients;

36. Special services, panel status, or certification such as California Children's Services (CCS) and expiration; and

37. Supervising Physician full name and license number for mid-level Providers, when applicable.

B. CalOptima Health's Provider and Web-based Directories shall include:

1. All Providers who contract with a Health Network and CalOptima Health Community Network (CHCN) to deliver health care services to Members including, but not limited to:

    a. Physicians and surgeons;

    b. Indian Health Care Providers (IHCPs), nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, Doulas, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service Providers, nurse midwives, and dentists;

    c. Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHF), Rural Health Clinics (RHCs), and primary care clinics to the extent they are available in CalOptima Health service area;

    d. Health Home Program Providers;

e. Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and

f. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

2. Identification of Providers that are not available to all or new Members.

3. Instructions and information on how to use the Directory. The instructions shall describe and explain any acronyms and symbols used within the Provider Directory, information on how to use CalOptima Health services, and who to call for assistance.

   a. The Directory shall be available in threshold languages, in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services., and PA.1007: Delivery of PACE Services.

4. A statement informing Members that they are entitled to language interpreter services at no cost, including contact information on how to obtain language services.

5. Instructions on how to contact CalOptima Health if the Provider Directory information appears to be inaccurate.

6. Instructions on how to contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman if the Provider Directory information appears to be inaccurate.

7. Instructions advising Members to contact Customer Service to verify the availability of selected Providers or to request additional information, such as Provider race/ethnicity data, physician education and training, and other relevant details as required by Member Experience (ME) 2, Element A, Factor 7 of the 2024 Health Plan (HP) Standards and Guidelines.

8. A disclosure statement assuring Members of full and equal access to Covered Services, regardless of disability status.

9. A listing of the physical accessibility indicators with the accessibility symbol listed before the word "Accessibility" pursuant to DHCS guidance and CalOptima Health Policy GG.1608: Full Scope Site Reviews.

C. Health Networks, CHCN, Delegated Provider Groups, or a Provider (as applicable) shall submit to the Provider Data Management Services (PDMS) Department a written request to add, change, or terminate a Provider from the CalOptima Health Provider Directory or Web-based Directory as follows:

1. Provider Additions: Minimum of thirty (30) calendar days advanced written notice;

2. Provider Changes: Minimum of thirty (30) calendar days advanced written notice; and

3. Provider Terminations: Minimum of ninety (90) calendar days advanced written notice in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

D. On a semi-annual basis, a Health Network and CHCN will require contracted Providers to confirm that their information in the Provider Directory is accurate and/or update the information, if applicable.

E. CalOptima Health shall maintain a process and system by which Providers may submit verification or changes to their listed information in the Provider Directory in a manner consistent with guidance from the DHCS and applicable contractual obligations.

F. CalOptima shall maintain a process to continuously validate provider's Medi-Cal Enrollment status consistent with DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment if there is a state-level enrollment pathway.

G. Health Network, CHCN, Delegated Provider Group, or Provider Request to Add a Provider

1. CalOptima Health's PDMS Department shall add a Health Network, Delegated Provider Group and/or CHCN Provider to the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Health Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. CalOptima Health requires its Health Networks, subdelegates, Delegated Provider Groups, Providers and practitioners to promptly inform CalOptima Health of any changes to information regarding Provider demographics, credentialing, panel status, and other information requested on the CalOptima Health ACT form (Attachment A) or electronic notification (with applicable data) to ensure data accuracy, integrity and to audit/confirm the information provided by its Providers is true and correct.

2. A Health Network, CHCN, Delegated Provider Group, or Provider add request shall include:

a. CalOptima Health (ACT) form (Attachment A) (recommended) or electronic notification with applicable data;

b. Signed W9 form;

c. Health Network contract front and signature page (if applicable);

d. Provider Profile: a complete Provider profile that includes the following information:

i. Legal, full name of the Provider, as shown on his or her medical license;

ii. Program information (contracted CalOptima Health programs) and effective date;

iii. Gender;

iv. Primary, secondary, and tertiary specialty, as applicable;

v. Board certified specialty, if applicable;

vi. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

vii. Area of focus, if applicable;

viii. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

ix. State license number;

x. Address, phone and facsimile number for the Provider service location;

xi. Days and hours of operation;

xii. Hospital affiliation(s);

xiii. Accepting new patients;

xiv. Accepting existing Members;

xv. Available by referral only;

xvi. Available only through a hospital or Facility; or

xvii. Not accepting new patients;

xviii. Accepting new and existing patients

xix. Age limits (member age minimum, member age maximum, gender restrictions);

xx. Languages spoken by the physician including American Sign Language;

xxi. Languages spoken by clinical staff;

xxii. Telehealth Provider indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person.

xxiii. Telehealth site indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person;

xxiv. Medi-Cal enrolled (Y/N) and effective date;

xxv. Medicare enrolled (Y/N); and

xxvi. A copy of the "Provider Directory Listing Authorization" section of the physician profile for mid-level practitioners, when applicable.

e. For Facilities, a complete Facility profile that includes the following information:

i. Facility name;

ii. Location;

iii. Accreditation;

iv. Phone number;

v. NPI;

vi. Languages spoken at Facility; and

vii. Telehealth indicator, site location.

3. A Health Network, CHCN, Delegated Provider Group, or Provider shall submit a request to the PDMS Department by one (1) of the following methods:

   a. E-mail to ProviderOnline@caloptima.org; or

   b. Fax to 714-954-2330.

4. If discrepancies are identified, the PDMS department shall reject and return the request to the requesting Health Networks, CHCN, Delegated Provider Group, or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

5. The PDMS Department shall update the Provider or Facility file(s) in the Provider information system and, subsequently, the Web-based Directory, within five (5) business days of receipt of completed information.

6. The PDMS department shall ensure provider NPIs are validated and added to the 274 Network Provider File, including but not limited to PCPs, Specialists, and Dyadic Care Services.

H. Health Network, CHCN, Delegated Provider Group, or Provider Request to Change demographic or other information for a Provider, Practitioner or Facility.

1. CalOptima Health's PDMS Department shall update demographic or other information in the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Health Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. A Health Network, CHCN, Delegated Provider Group, or Provider change request shall include:

   a. Legal, full name of the practitioner, as shown on his or her medical license;

   b. Program information (contracted CalOptima Health programs) and effective date;

   c. Primary, secondary, and tertiary specialty, as applicable;

   d. Board certified specialty, if applicable;

   e. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

   f. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

g. Tax identification number (TIN);

h. State license number;

i. Gender;

j. Address, telephone and facsimile number for the Provider service location, including a telephone number for after normal business hours, if applicable;

k. Days and hours of operation;

l. Hospital affiliation;

m. Accepting new patients;

n. Age limits (Member age minimum, Member age maximum, gender restrictions);

o. Languages spoken by the physician including American Sign Language;

p. Languages spoken by clinical staff;

q. Telehealth Provider indicators:

   i. Only Telehealth;

   ii. No Telehealth (only in-person); or

   iii. Both telehealth and in-person;

r. Telehealth site indicators:

   i. Only Telehealth;

   ii. No Telehealth (only in-person); or

   iii. Both telehealth and in-person;

s. Medi-Cal enrolled (Y/N) and effective date; and

t. Medicare enrolled (Y/N).

2. A Health Network, CHCN, Delegated Provider Group, or Provider shall submit requests for Provider changes to the PDMS Department by one (1) of the following methods:

   a. E-mail to: ProviderOnline@CalOptima.org; or

   b. Fax to: 714-954-2330.

3. If discrepancies are identified, the PDMS department shall return the profile to the requesting Health Networks, CHCN, Delegated Provider Group or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

4. The PDMS Department shall update the Provider or Facility file(s) in the provider information system and the web-based directory within thirty (30) calendar days of receipt of completed information.

I. Health Network, CHCN, Delegated Provider Group, or Provider Request to Terminate a Provider or Facility:

1. CalOptima Health 's PDMS Department shall terminate a Provider or Facility in the system of record within five (5) business days of submission based on the termination date indicated on the CalOptima Health ACT form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. A Health Network, CHCN, Delegated Provider Group, or Provider termination request shall include:

   a. A copy of the Provider or Facility termination notice with the effective date for termination.

   b. For a PCP who terminates from CHCN and requests to maintain the relationship with the Member:

      i. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

      ii. The PCP must have an active affiliation and their panel status "open" with the selected Health Network the Members are being assigned to.

2. For terminating Providers, CalOptima Health or the Health Network shall notify affected Members and DHCS, as applicable, in accordance with CalOptima Health Policies DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment, DD.2008: Health Network Selection Process, DD.2012: Member Notification of Change in the Availability or Location of Covered Services, MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services. The PDMS Department shall notify Customer Service of Provider termination for purpose of Member notification and re-assignment of Members.

J. On a weekly basis, the PDMS Department shall send to the Health Networks and CHCN Provider, Practitioner and Facility reports of Additions, Changes, and Terminations for review of accuracy.

1. If discrepancies are identified on any Provider files, Health Networks and CHCN shall address the discrepancies.

   a. Upon addressing discrepancies, the Health Network or CHCN shall notify the PDMS Department.

   b. The PDMS Department shall update the Provider, practitioner and Facility files within five (5) business days in the provider information system and shall update the Web-based Directory.

K. On a monthly basis, CalOptima Health shall obtain an electronic update from the National Committee on Quality Assurance (NCQA) regarding providers who achieve Patient-Centered Medical Home (PCMH) recognition status. The updates from NCQA shall be seen on the Web-based Directory within ten (10) calendar days after receipt of the data file from NCQA.

L. Verification of Provider Information

1. CalOptima Health and Health Networks shall verify and update all information outlined in Section III.A. of this Policy to ensure accuracy of the information listed in the Provider Directory and Web-based Directory. CalOptima Health and Health Networks shall notify contracted Providers of the requirement to maintain and attest to the accuracy of Provider Directory information.

    a. Notification

        i. On a semi-annual basis, CalOptima Health shall notify and instruct Providers of the process to verify or update information listed in the Provider Directory and Web-based Directory, in a manner consistent with guidance from DHCS and applicable contractual obligations.

    b. Verification

        i. On a semi-annual basis, CalOptima Health shall distribute a Provider Data Universe to Health Networks and CHCN in the first (1st) and third (3rd) quarter of each calendar year.

        ii. Health Networks and CHCN shall conduct validation of all information listed in the Provider Data Universe in accordance with this Policy.

        iii. Health Networks and CHCN shall document the outcome of each attempt to verify Provider information.

        iv. If through this process, a Health Network or CHCN discovers a Provider has retired, ceased practicing, or if the Provider is no longer affiliated with a practice, CalOptima Health shall remove the Provider from the Provider Directory in accordance with Section III.H. of this Policy.

    c. Provider Directory Validation Attestation

        i. Health Networks and CHCN shall require contracted Providers to validate and attest in writing to the accuracy of their Provider Directory information.

        ii. If a Provider fails to respond to the request for validation and written attestation within thirty (30) business days, Health Networks and CHCN shall attempt to verify if the Provider information is accurate or requires updating within fifteen (15) business days.

        iii. If a Health Network or CHCN is unable to verify whether the Provider's information is accurate or requires updating, a notice shall be sent to the Provider informing them of the intent to remove them from the Provider Directory for failure to submit appropriate validation and written attestation in accordance with this Policy.

            a) Health Networks and CHCN shall notify Providers ten (10) business days prior to removal from the Provider Directory.

                i) Providers that fail to respond will be removed from the Provider Directory in accordance with Section III.H. of this Policy.

ii) Providers will not be removed from the Provider Directory if a response is received before the end of the tenth (10th) business day.

iv. A Provider's failure to validate and attest to the accuracy of their Provider Directory data may result in panel closure, suppression from the Provider Directory, and/or delay of payment.

v. General acute care hospitals shall not be required to provide a response.

d. Collection and Submission of Provider Attestation

i. Health Networks and CHCN shall collect written Provider attestations from all contracted Providers for annual submission to the CalOptima Health Audit and Oversight Department.

ii. Health Networks and CHCN shall submit written Provider attestations, as requested by CalOptima Health 's Audit and Oversight department, in the fourth (4th) quarter of each calendar year.

iii. Written Provider attestations must be stored electronically for a minimum of ten (10) years.

M. Access to CalOptima Health Provider Directory and Web-based Directory

1. CalOptima Health shall provide Members, prospective Members, Providers and members of the public information from the CalOptima Health Provider Directory and Web-based Directory in alternate media formats. Alternate media formats include:

a. Print

i. CalOptima Health staff shall send by U.S. Postal Service mail to new Members the CalOptima Health Provider Directory upon enrollment in the CalOptima Health program or by request, postmarked no later than five (5) business days following the date of the request and in accordance with CalOptima Health Policy DD.2008: Health Network Selection Process; or

b. Telephone

i. CalOptima Health staff shall utilize the Web-based Directory to assist Members over the phone in finding a Provider. If a Member requests Provider information or the CalOptima Health Provider Directory, CalOptima Health staff shall print and send the requested information to the Member by U.S. mail.

N. CalOptima Health shall review its Web-based Directory for usability every three (3) years. Review shall include, but is not limited to:

1. Font size;

2. Reading level;

3. Ease of navigation;

4. Intuitive content organization; and

5. Directories in different languages.

O. Validation of Web-based Directory

1. A Health Network and CHCN shall validate the Web-based Directory Provider, Practitioner and Facility information at least annually. Validation shall consist of the following:

   a. Data sources, and

   b. Limitations for each item of information on the Web-based Directory.

2. Web-based Directory Provider, Practitioner and Facility validation and frequency table:

	Provider Definition	**Information Collection and Validation**
Name	The alternative name preferred by and as specified by the practitioner, provider, or Facility which may be familiar to patients and can be published on provider directory.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Type	Includes: Physicians and surgeons; Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists; Federally Qualified Health Centers (FQHCs) or primary care clinics; Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
License Number	California license number of the practitioner. Catenate the license type letter (NP, CNM, and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
NPI	National provider identifier of the practitioner (NPI type 1, 10 digits) National provider identifier of the hospital (NPI type 2, 10 digits)	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Gender	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Address	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice City	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice State	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Zip Code	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between the validation time frames.
After Hours Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Age Limits	Member age minimum, member age maximum and gender restriction.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Specialty	The clinical area in which the CalOptima Health contracted physician received specialized training, such as a residency or fellowship.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Taxonomy (primary, secondary, tertiary)	The taxonomy code of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Area of Focus	The specific focus of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
Facility Hospital Affiliations (Hospital Name)	The name of CalOptima Health contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames
Hospital Admitting Privileges	Includes: Active, Provisional, Courtesy, Surgical, Consultant, Suspended, Limited, Associate Staff, Honorary Staff, and Senior Attending.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Board Certification	When a health care practitioner is board certified, it means that he or she has applied for and been awarded certification from the American Board of Medical Specialties (ABMS), American Osteopathic Association, or other recognized board. Board certification is a voluntary process. To become board certified, a physician must: • Graduate from an accredited professional school • Complete a specific type and length of training in a specialty • Practice for a specified amount of time in that specialty • Pass an examination given by the professional specialty board For more information about your physician's board certification, visit the ABMS website at www.abms.org	Information is self-reported and updated every three (3) years during re-credentialing. Changes may occur between validation time frames.
Acceptance of New Patients	Indicates whether the provider is accepting new patients, accepting existing patients, accepting new and existing patients, accepting through referral only, accepting through a hospital or Facility, not accepting new patients.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Language or Languages including American Sign Language	The languages other than English that the provider speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
Clinical Staff Languages	The languages other than English that the clinical staff speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Telehealth Provider indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Provider indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Telehealth site indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Site indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Physical Accessibility Compliance	Refers to a site, Facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability.	Upon completion of a provider Facility site review, by using the data obtained through Attachment C of the FSR tool to determine and identify physical accessibility indicators.
Medical Group Affiliations	A group of contracted physicians that provides health care services to CalOptima Health Members.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Health Network Affiliations	A group of doctors and hospitals that provides health care services and has a contract with CalOptima Health.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
CalOptima Health Program (product)	The line of business the provider and/or Facility participates in	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Special Services	Services that the provider is certified in such as CCS.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Administrative Email Address	For office contact only.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Web URL Address	If applicable.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Public Email Addresses	Public email address (if applicable and attestation is completed) for patient communications.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Office Days and Hours	Days and times the provider and/or Facility is open for business.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
Supervising Physician Full Name and License Number for Mid-level Practitioners	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

3. CalOptima Health 's Quality Improvement Department shall validate the Web-based Directory Hospital information every three (3) years. Validation shall consist of the following:

    a. Data sources; and

    b. Limitations for each item of information on the Web-based Directory.

4. Web-based Directory Facility validation and frequency table:

	Facility Definition	Information Collection and Validation
Facility	General acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Facility Name	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Location	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Accreditation	Identifies whether the Facility undergoes a review to assess the quality of its systems and processes by an external accreditation organization.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Hospital Quality Data from Recognized Sources	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.

IV. ATTACHMENT(S)

A. CalOptima Health Add/Change/Term (ACT) form
B. ACT Form User Guide
C. National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy Code Set

V. REFERENCE(S)

A. CalOptima Health Contract for Health Provider Care Services
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
G. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
H. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
I. CalOptima Health Policy GG.1608: Full Scope Site Reviews
J. CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
K. CalOptima Health Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
L. Health and Safety Code (HSC), §1367.27
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
N. 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)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised November 3, 2023)
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. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 00-002: Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
S. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 11-009: Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
T. National Committee of Quality Assurance (NCQA) 2024 Health Plan (HP) Standards and Guidelines
U. NUCC Taxonomy Code List: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
V. Title 42, Code of Federal Regulations (CFR), § 438.10(h)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/17/2014	Department of Health Care Services (DHCS)	Approved As Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/06/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved As Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved As Submitted
07/03/2023	Department of Health Care Services (DHCS)	Approved As Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved As Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
02/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/15/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2017	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	02/03/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	01/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	11/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	05/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	09/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	12/05/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Delegated Provider Group	Health care entity with authority to credential its health care practitioners.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024: Doula Services.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
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.
Member	A beneficiary enrolled in a CalOptima Health program.
National Uniform Claim Committee (NUCC)	The official maintainer of the Health Care Provider Taxonomy code set. https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Term	Definition
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.
Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.