Policy:	GG.1110
Title:	**Primary Care Practitioner Definition, Role, and Responsibilities**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	10/01/1995
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the Primary Care Practitioner (PCP) role and responsibilities in providing Covered Services and Case Management to Members.

II. POLICY

A. A Member shall select a PCP or be assigned to a PCP as follows:

1. For Medi-Cal Members: In accordance with CalOptima Health Policies EE.1112: Health Network Eligible Member Assignment to Primary Care Provider, or AA.1207a: CalOptima Health Auto Assignment.

2. For OneCare Members: In accordance with CalOptima Health Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification.

B. A Member who selects or is assigned to a PCP shall receive Covered Services that are coordinated by his or her PCP or a Practitioner to whom he or she has been referred to by the PCP.

C. PCP requirements

1. A PCP shall be enrolled as a Medi-Cal provider prior to having a contractual relationship with CalOptima Health or a Health Network.

2. A PCP shall be credentialed by each of his or her affiliated Health Network(s) or CalOptima Health in accordance with CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners.

3. A PCP shall provide to a Member those authorized services that are within his or her scope of practice.

4. A PCP may limit his or her practice to adult, pediatric, or a combination of both Member populations. Additionally, obstetricians and gynecologists may limit their practice to female Members.

5. A PCP shall have a broad-based education with training that is supported by demonstrated ability and experience in providing primary care, including ongoing participation in continuing medical education focused on primary care subjects.

6. A Specialty Care Provider (SCP) may function as a PCP if he or she meets the criteria above and is recognized as a PCP by his or her affiliated Health Network(s) or CalOptima Health.

D. PCP responsibilities include, but are not limited to:

1. Reasonable efforts to verify eligibility of the Member at the time services are provided;

2. Providing care for the majority of health care problems presented by a Member, including preventive, acute, and chronic health care;

3. Providing risk assessment, treatment planning, coordination of Medically Necessary services, referral, follow-up, and monitoring of appropriate services and resources required to meet a Member's health care needs, including coordination of care and referral for carved-out and linked services that are not the direct responsibility of CalOptima Health (e.g., specialty mental health services, dental services);

a. Behavioral Health Services shall be coordinated by the PCP in accordance with CalOptima Health Policies GG.1900: Behavioral Health Services, and MA.7020: Behavioral Health Services.

4. Providing medical Case Management to assigned Members in accordance with CalOptima Health Policies GG.1301: Comprehensive Care Management Process, and MA.6009: Care Management and Coordination Process, within the following medical Case Management goals:

a. Ensuring continuity of care for a Member and an interactive relationship between the PCP and the Member;

b. Increasing Member satisfaction;

c. Facilitating access to appropriate health services;

d. Reducing unnecessary referrals to Specialty Care Providers and reducing inappropriate emergency department utilization;

e. Controlling inappropriate use of pharmacy and drug benefits;

f. Screening health status, monitoring, and providing preventive health services;

g. Identifying and providing appropriate health education to improve a Member's understanding of the importance of a healthy lifestyle and disease-specific interventions; and

h. Participating in Interdisciplinary Care Team (ICT) meetings, as appropriate, in accordance with CalOptima Health Policies GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management, and MA.6032: Model of Care.

5. Providing Basic Population Health Management (BPHM), in accordance with CalOptima Health Policy GG.1667: CalAIM Population Health Management Program for members who are engaged in primary care and BPHM has been delegated to the PCP;

6. Assuring the provision of the required scope of services to the assigned Members;

7. Assuring access to care twenty-four (24) hour per day, seven (7) days per week, including accommodations for urgent care, performance of procedures, inpatient rounds, and arrangements for emergency and back-up coverage in the PCP's absence;

8. Ensuring effective communication regarding treatment, diagnosis, medical history, and health education by providing culturally, linguistically, and sensory appropriate services to Members, in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services.

9. Ensuring compliance with Timely Access to Care Standards regarding in-office wait times in accordance with CalOptima Health Policies GG.1600: Access and Availability, and MA.7007: Access and Availability.

10. Coordinating and directing appropriate care for Members, including:

    a. Initial Health Appointment (IHA): IHA completed for Medi-Cal Members within one-hundred twenty (120) calendar days after enrollment in CalOptima Health Medi-Cal, in accordance with CalOptima Health Policy GG.1613: Initial Health Appointment;

        i. Any follow-up services which are necessary given the findings or risk factors identified in the IHA shall be initiated as soon as possible but no later than sixty (60) calendar days following discovery of a problem requiring follow up.

    b. A review of the Initial Health Risk Assessment (HRA) that is completed and scheduled within specified timeframes as outlined in CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment.

    c. Cognitive Health Assessment: CalOptima Health shall make available a Cognitive Health Assessment for Members who are sixty-five (65) years of age or older and who do not have Medicare coverage as a component of an Evaluation and Management (E&M) visit.

        i. Providers conducting the Cognitive Health Assessment must complete the required Department of Health Care Services (DHCS) Dementia Care Aware cognitive health assessment training with at least one DHCS approved cognitive assessment tool, as indicated in DHCS All Plan Letter (APL) 22-025: Responsibilities For Annual Cognitive Health Assessment for Eligible Members 65 Year of Age or Older, and in accordance with CalOptima Health Policy EE.1103: Provider Network Training, prior to:

            a) Conducting the Cognitive Health Assessment; and

            b) Billing and receiving reimbursement for the Cognitive Health Assessment.

        ii. CalOptima Health shall ensure that Providers are providing the appropriate necessary follow-up services which may include but are not limited to additional assessments or specialist referrals.

d. Adherence to evidence-based clinical practice guidelines reviewed, adopted, and disseminated by CalOptima Health;

e. Second opinions as necessary;

f. Consultation with a referral specialist (including providing necessary history and clinical data to assist the specialist in his or her examination of the Member);

g. Follow-up care to assess results of the primary care treatment regimen and specialist recommendations; and

h. Special treatment within the framework of integrated, continuous care.

11. Coordinating the authorization of specialist and non-emergency hospital services for a Member, and ensuring that such services generated from referrals are initiated within thirty (30) calendar days after the visit at which the referral was made;

12. Assuring the provision of basic clinical services including primary evaluation and treatment of acute and chronic medical and surgical problems in all systems;

13. Recording all appropriate information in the Member's Medical Record, in accordance with CalOptima Health Policy GG.1603: Medical Records Maintenance, and making records available for review upon request by CalOptima Health, the Member's Health Network, the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services, and other applicable regulatory agencies and subcontractors;

14. Facilitating and ensuring Member quality of care by establishing procedures to contact a Member when the Member misses an appointment that requires rescheduling for additional visits, and following up on referrals to a specialist for care;

15. Using the CalOptima Health grievance and appeals procedures as set forth in CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and/or MA.9006: Contracted Provider Complaint Process;

16. Assisting Members in the use of the CalOptima Health grievance and appeals procedures as follows:

    a. For CalOptima Health Medi-Cal Members: As set forth in CalOptima Health Policies GG.1510: Member Appeal Process, HH.1102: Member Grievance, and HH.1103: Health Network Member Grievance and Appeal Process.

    b. For CalOptima Health OneCare Members: As set forth in CalOptima Health Policies MA.9002: Member Grievance Process, MA.9003: Standard Pre-Service Appeal, MA.9015: Standard Integrated Appeals.

17. Coordinating the transfer of a Member and related Medical Records to another Provider or Practitioner upon request by the Member, the Member's Health Network, or CalOptima Health;

18. Making all reasonable attempts to communicate with a Member in the Member's preferred language, including utilizing interpretation and/or translation services available through a Member's Health Network and/or CalOptima Health; and

19. Preserving the dignity of the Member.

E. A Provider or Practitioner shall not bill a Member for the provision of Covered Services in accordance with Title 22 of the California Code of Regulations, Section 51002.

F. A PCP shall accept contract fees as payment, or in absence of a contract, CalOptima Health rates.

G. A PCP shall participate in, and accept, continuing peer review of the medical or surgical services provided to the Member.

H. A PCP shall permit review of services provided to Members by the Health Network, CalOptima Health, DHCS, or its subcontractors, CMS or its subcontractors, and the U.S. Department of Health and Human Services.

I. CalOptima Health shall not prohibit, penalize, discourage, or otherwise restrict a PCP, acting within his or her scope of practice, from advising or advocating on behalf of a Member who is a patient of such health care professional about:

1. The Member's health status;

2. The Member's medical care;

3. Treatment options, including;

a. Any self-administered, alternative treatments, and

b. The provision of sufficient information to the Member to offer an opportunity to decide among all relevant treatment options, including the right to refuse treatment.

4. The risks, benefits, and consequences of treatment or non-treatment; or

5. The opportunity for the Member to refuse treatment, and to express preferences about future treatment options.

III. PROCEDURES

A. Services for Pediatric Members

1. All Members under twenty-one (21) years of age shall be provided with an IHA within specified timeframes as outlined in CalOptima Health Policy GG.1613: Initial Health Appointment, as part of the Pediatric Preventative Services furnished to Members in accordance with CalOptima Health Policy GG.1116: Pediatric Preventive Services, CalOptima Health's Contract with the Department of Health Care Services (DHCS), and applicable state and federal regulations.

2. The requirements for each periodic preventive health assessment include:

a. Comprehensive health and developmental history (including assessment of both physical and mental health development);

b. Unclothed physical examination, including assessment of physical growth;

c. Assessment of nutritional status;

d. Vision screen;

e. Dental screen, including inspection of mouth, teeth, and gums;

f. Hearing screen;

g. Provision of immunizations in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP);

h. Laboratory tests appropriate to age, sex, and history;

i. Tuberculin (TB) test according to the latest standards recommended by the Centers for Disease Control Guidelines for TB control. Provisions shall be made to read and record the result of each test;

j. Testing for sickle cell trait, when appropriate; and

k. Blood Lead Screening in accordance with CalOptima Health Policy GG.1717: Blood Lead Screening of Young Children.

3. Health education and anticipatory guidance appropriate to age and health status.

4. Pediatric PCPs shall participate in the Vaccines for Children (VFC) Program.

5. A PCP shall refer a Member three (3) years of age or older, to a dentist annually, or more frequently, if indicated.

B. Services for Adult Members

1. Adults shall receive preventive care services according to the latest recommendations of the United States Public Health Service. Preventive care and service guidelines shall include:

a. Appropriate periodic physical examinations;

b. Immunizations based on all U.S. Food and Drug Administration (FDA) approved adult vaccines recommended by ACIP and their administration, as well as recommended immunizations included on the Medi-Cal FFS contract drug list as a pharmacy benefit;

i. Recommended immunizations must be provided as preventive services and shall not be subject to Prior Authorization or cost sharing.

c. Counseling and health guidance;

d. Age and sex appropriate screening;

e. Diagnostic tests and laboratory services;

f. Recommendations and referrals for continuing or specialized care for a specific diagnosis; and

g. Recommendations for high risk groups (e.g., HIV, AIDS, Sickle Cell Disease).

2. A PCP shall document in a Member's Medical Record attempts to provide preventive screenings, receipt of such screenings, and results, or voluntary refusal of such services. Documentation of declination of services includes:

   a. A signed statement by the Member or the Member's Authorized Representative; or

   b. Dated documentation of the Member's or Authorized Representative's response to an in-person or telephone contact.

C. Other Responsibilities

1. An obstetrical Practitioner shall complete the CalOptima Health Pregnancy Notification Report for a pregnant Member in accordance with CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program.

2. A PCP shall inform a Member or the Member's Authorized Representative of the availability of the Supplemental Nutrition Program for Women, Infants, and Children (WIC) services and refer the Member to these services as needed.

3. A PCP shall refer a Medi-Cal eligible Member to Medi-Cal services that are not CalOptima Health Covered Services, as appropriate (e.g., Dental Services, Mental Health Services).

4. A PCP may identify Members with a potentially California Children's Services-Eligible Condition and may submit a request for CCS eligibility determination to CalOptima Health in accordance with CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program.

D. Delegation of Treatment Responsibility

1. The PCP shall ensure access to physician care for assigned Members twenty-four (24) hours per day, seven (7) days per week.

2. The PCP shall designate a back-up Practitioner and provide a mechanism for the Member to access the back-up Practitioner when he or she is unavailable to provide coverage to assigned Members.

3. Payment for the PCP's back-up coverage is the sole responsibility of the PCP.

4. Providers and Practitioners rendering Emergency Services, authorized services, or services that do not require prior authorization as defined by CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct Providers, and GG.1508: Authorization and Processing of Referrals, shall be paid contract fees as payment, or in the absence of a contract, CalOptima Health rates in accordance with CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible.

5. If a Member requires continuing specialty care, the Member's PCP may request authorization for the specialist to provide ongoing care for a specified period of time. Authorization for services shall be processed in the same manner as any other referral for specialist services. The PCP shall retain responsibility for the Member as the PCP.

E. Use of Non-Physician Medical Practitioners

1. When a PCP employs a physician assistant (PA), nurse practitioner (NP), or certified nurse-midwife (CNM), the Non-Physician Medical Practitioner shall be supervised by the physician in the provision of care and directed according to Medi-Cal and/or Medicare regulations (as applicable), California state regulations, licensure requirements, and CalOptima Health policy.

2. The supervising physician shall have an appropriate certification from the Medical Board of California to supervise a PA. The PA shall hold a current license to practice.

3. An NP or CNM shall hold a current professional license for the position and act according to the agreed upon protocols and interface requirements cited in California state regulations.

F. In the interest of program integrity and the safety and welfare of a Member, CalOptima Health or a Member's Health Network may introduce utilization controls, as necessary, at any time, and without advance notice to the PCP. Such changes shall take place immediately and shall be based upon review of trends and variations from expected patterns of resource utilization for the Membership. Examples of utilization controls may include, but are not limited to:

1. Use of increased intensity of review for any Provider or Practitioner identified as failing to maintain standards, including appropriate referrals, follow-up, and coordination of services.

2. Mandatory education of the Provider or Practitioner in managed care principles regarding wellness goals, preventive services, and pharmacy utilization.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. American College of Obstetricians and Gynecologists, District IX
B. California Business and Professions Code, §2056.1
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, Health Network Service Agreement
F. CalOptima Health Policy AA.1207a: CalOptima Health Auto Assignment
G. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
H. CalOptima Health Policy EE.1103: Provider Network Training
I. CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider
J. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
K. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program
L. CalOptima Health Policy GG.1116: Pediatric Preventive Services
M. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
N. CalOptima Health Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management
O. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and

CalOptima Health Community Network Providers
P. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
Q. CalOptima Health Policy GG.1510: Member Appeal Process
R. CalOptima Health Policy GG.1600: Access and Availability Standards
S. CalOptima Health Policy GG.1603: Medical Records Maintenance
T. CalOptima Health Policy GG.1613: Initial Health Appointment
U. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
V. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
W. CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program
X. CalOptima Health Policy GG.1717: Blood Lead Screening of Young Children
Y. CalOptima Health Policy GG.1900: Behavioral Health Services
Z. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
AA. CalOptima Health Policy HH.1102: Member Grievance
BB. CalOptima Health Policy HH.1103: Health Network Member Grievance and Appeal Process
CC. CalOptima Health Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
DD. CalOptima Health Policy MA.6009: Care Management and Coordination Process
EE. CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment
FF. CalOptima Health Policy MA.6032: Model of Care
GG. CalOptima Health Policy MA.7007: Access and Availability
HH. CalOptima Health Policy MA.7020: Behavioral Health Services
II. CalOptima Health Policy MA.9002: Enrollee Grievance Process
JJ. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
KK. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
LL. CalOptima Health Policy MA.9015: Standard Integrated Appeals
MM. CalOptima Health Provider Manual: https://www.caloptimahealth.org/EN/Providers/ManualsPoliciesAndResources.aspx
NN. Child Health and Disability Prevention (CHDP) Program Guidelines, California Department of Health Care Services: https://www.dhcs.ca.gov/services/chdp/Pages/default.aspx
OO. Guide to Clinical Preventive Services, Williams and Wilkins
PP. Guidelines for Health Supervision, American Academy of Pediatrics
QQ. Joint Statement on Primary Care Providers: California Academy of Family Practice
RR. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-016: Blood Lead Screening of Young Children (supersedes APL 18-017)
SS. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-034: California Children's Services Whole Child Model Program (supersedes APL 21-005)
TT. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Policy Guide (supersedes APLs 17-012 and 17-013)
UU. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older
VV. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements (Supersedes APLs 18-004 AND 16-009)
WW. Health and Safety Code §1367.69
XX. Title 17, California Code of Regulations (C.C.R), § 37000 et seq.
YY. Title 22, California Code of Regulations (C.C.R), § 51002 & 51340(e)(3)
ZZ. Title 28, California Code of Regulations (C.C.R), § 1300.67
AAA. Title 42, Code of Federal Regulations (C.F.R), § 422.206

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/29/2020	Department of Health Care Services (DHCS)	Approved as Submitted
03/22/2022	Department of Health Care Services (DHCS)	Approved as Submitted
03/29/2023	Department of Health Care Services (DHCS)	Approved as Submitted
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1110	PCP Definition, Role, and Responsibilities	Medi-Cal
Revised	01/01/2009	GG.1110	PCP Definition, Role, and Responsibilities	Medi-Cal
Revised	09/01/2014	GG.1110	PCP Definition, Role, and Responsibilities	Medi-Cal
Revised	11/01/2015	GG.1110	PCP Definition, Role, and Responsibilities	Medi-Cal
Revised	12/01/2016	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal
Revised	04/01/2017	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	10/01/2017	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	08/01/2018	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	04/01/2019	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	03/01/2020	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	12/01/2020	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	06/01/2021	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare
Revised	03/01/2023	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare
Revised	02/01/2024	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare
Revised	10/01/2024	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
Behavioral Health Services	Services which encompass both Mental Health and Substance Use Disorder services.
Blood Lead Screening	Testing an asymptomatic child for lead poisoning by analyzing the child's blood for concentration of lead.
California Children's Services (CCS)-Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
Case Management	Medi-Cal: A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation. OneCare: A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4

Term	Definition
	regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments;

Term	Definition
	15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and\ 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Emergency Services	Medi-Cal: Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a Provider qualified to furnish Emergency Services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
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.
Health Risk Assessment (HRA)	Medi-Cal: A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life. OneCare: A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.
Individual Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a PCP in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other Providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Member	A beneficiary enrolled in a CalOptima Health program.
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal

Term	Definition
	documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse Practitioner who provides primary care.
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.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.

Term	Definition
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) 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.
Specialty Care Provider (SCP)	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.