Policy:	HH.2021
Title:	**Exclusion and Preclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/ Michael Hunn 11/20/2024*
Effective Date:	05/01/2012
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines a process for verifying and Monitoring, the eligibility of Employees (permanent, temporary, volunteer, and as-needed Employees), Members of the Governing Body, First Tier, Downstream, and Related Entities (FDRs), non-contracted Providers, and vendors to participate in CalOptima Health federal and/or state health care programs through state and federal Exclusions, Preclusion, and ineligible person/entity lists.

II. POLICY

A. CalOptima Health shall ensure all Employees, Members of the Governing Body, FDRs, non-contracted Providers, and vendors are eligible to participate in CalOptima Health federal and/or state health care programs, and shall be responsible for:

1. Requiring an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor to disclose and report pending suspensions, Exclusions, Preclusions, or debarments, of the Employee, Member of the Governing Body, FDR, Providers, or vendor;

2. Conducting the initial eligibility verification of an Employee, Member of the Governing Body, FDR, non-contracted Provider, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima Health, or issuing payment thereto;

3. Performing eligibility verification of an Employee, Member of the Governing Body, FDR, non-contractor Providers, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

5. CalOptima Health shall not employ, consult, or contract with individuals or entities that are determined to be suspended, debarred, precluded, or Excluded from participation in federal or state health care programs. Individuals or entities identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality can remain contracted with CalOptima Health as long as the individuals or entities are not listed on a federal or California exclusion list including, but not limited to:

a. The General Services Administration's (GSA) System for Award Management (SAM) website;

b. Medi-Cal's Suspended and Ineligible (S&I) list;

c. CMS Preclusion List;

d. Medi-Cal Restricted Provider Database (RPD);

e. Medi-Cal Procedure/Drug Code Limitation List;

f. OIG Exclusion Database (OIG LEIE Database);

g. Other Monitoring sources as identified in CalOptima Health Policies:

B. CalOptima Health shall not reimburse or make payment for services provided under the medical direction or on the prescription of an Excluded person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, precluded, or Excluded from participation in federal or state health care programs.

1. Payment exception for services or items rendered to CalOptima Health Medi-Cal Members: CalOptima Health and its FDRs must not pay any amount for any services or items other than Emergency Services to an Excluded Provider as defined by DHCS. This prohibition applies to non – Emergency Services or items furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had reason to know of the Exclusion, or by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of Fraud.

C. CalOptima Health will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor for all CalOptima Health programs, or the appointment of a Member of the Governing Body, if such individual or entity is verified to be suspended, debarred, Precluded or Excluded from participation in federal or state health care programs.

D. CalOptima Health shall utilize state and federal Preclusion, Exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor and shall maintain a record of completion.

E. All CalOptima Health FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion.

F. In the event a CalOptima Health FDR or vendor identifies its employees and/or Downstream Entities on an Exclusion, Preclusion, and/or ineligible person/entity list, the FDR or vendor must immediately notify CalOptima Health of the identified ineligible person/entity. CalOptima Health in its sole discretion will determine whether it is appropriate to immediately suspend/remove/terminate the identified person/entity from furnishing items and services for CalOptima Health programs and/or suspend/terminate the applicable FDR or vendor contract.

G. The Office of Compliance may Audit CalOptima Health departments responsible for exclusion and Preclusion activities, as necessary.

H. CalOptima Health may contract with a Network Provider and/or Subcontractor that has been suspended or excluded from participation in the Medi-Cal program when the suspension and/or Exclusion has been lifted.

III. PROCEDURE

A. Initial Verification

1. Prior to hiring an Employee, having an individual become a Member of the Governing Body or a CalOptima Health committee, or contracting with an FDR or vendor, or approving payment to a non-contracted Provider the responsible department identified in the chart in Section III.B.2. of this Policy shall verify that the individual or entity is not Excluded or Precluded by reviewing the applicable Monitoring sources to retrieve verification and eligibility data, including, but not limited to:

    a. The General Services Administration's (GSA) System for Award Management (SAM) website;

    b. Medi-Cal's Suspended and Ineligible (S&I) list;

    c. CMS Preclusion List;

    d. Medi-Cal Restricted Provider Database (RPD);

    e. Medi-Cal Procedure/Drug Code Limitation List;

    f. OIG Exclusion Database (OIG LEIE Database);

    g. Other Monitoring sources as identified in CalOptima Health Policies:

        i. GG.1607: Monitoring Adverse Actions;

        ii. GG.1650: Credentialing and Recredentialing of Practitioners; and

        iii. GG.1651: Assessment and Re-Assessment of Organizational Providers.

    h. As required by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS):

        i. DHCS All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.

B. Evidence of Verification

1. CalOptima Health shall utilize applicable state and federal Preclusion, Exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor and shall maintain a record of completion indicating, at minimum:

a. The date of verification;

b. The Exclusion, Preclusion, and ineligible person/entity list source(s);

c. Verification results; and

d. The name of the person who conducted the verification.

2. CalOptima Health is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly Exclusions and Preclusions checks thereafter.

Responsible Department	**Initial** (Prior to contracting/hire, or payment of a non-contracted Provider)	**Monthly**
Accounting	Great Plains vendors ONLY; excluding all vendors whose initial Monitoring is the responsibility of other departments listed in this grid.	• FDRs and Vendors listed in Great Plains ONLY • Health Networks in Great Plains ONLY • Letter of Agreement in Great Plains ONLY • Medical Group Practices, Physician Medical Groups in Great Plains ONLY • Non-Medical Providers in Great Plains ONLY
Contracting	• Health Networks	N/A
Human Resources	• Employees • CalOptima Health Committees • CalOptima Health Members of the Governing Body (Board of Directors)	• Employees • CalOptima Health Committees • CalOptima Health Members of the Governing Body (Board of Directors)
PACE	• PACE Vendors ONLY o This includes vendors that are NOT providing direct member care i.e., entertainment and will be invoiced • PACE Letter of Agreement (LOA) ONLY o This includes non-medical Providers i.e., handyman and medical Providers not contracted	• Refer to Accounting and/or Quality-Credentialing monthly Monitoring
Pharmacy Benefit Manager	• Pharmacies • Pharmacy Staff • Prescribers	• Pharmacies • Pharmacy Staff • Prescribers
Provider Data Management Services (PDMS)	• Medical Providers, Practitioners, Organizational Providers (OPs) NON-CONTRACTED ONLY	N/A

Responsible Department	Initial (Prior to contracting/hire, or payment of a non-contracted Provider)	Monthly
Quality- Credentialing	• Medical Providers, Practitioners, Organizational Providers (OPs) CCN CONTRACTED ONLY • Medical Group Practices • MSSP Non-Medical Providers • Physician Medical Groups • Letter of Agreement (LOA)	• Medical Providers • Practitioners • Organizational Providers (OPs) • Medical Group Practices • Physician Medical Groups • Letter of Agreement (LOA)
Utilization Management	• Letter of Agreement (LOA)	N/A
Vendor Management	• FDRs and Vendors excluding Medical Providers and Health Networks	N/A

3. All CalOptima Health FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities on applicable Monitoring sources as required by CMS and/or DHCS prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

    a. Date of verification;

    b. The Exclusion, Preclusion, and ineligible person/entity list source(s);

    c. Verification results; and

    d. The name of the person who conducted the verification.

C. Monitoring

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor Employees, FDRs, non-contracted Providers, vendors, and Members of the Governing Body and committees by reviewing the applicable Monitoring sources listed in section III.A.1. of this Policy.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, section 1001.1901(b)(1), CalOptima Health shall immediately suspend and halt payment for services for an ineligible, or Excluded, Employee, Member of the Governing Body or CalOptima Health committee, FDR, non-contracted Provider, or vendor; or at the medical direction or on the prescription of a physician or an authorized individual who is Excluded when the person furnishing such item or service knew, or had reason to know, of the Exclusion. The payment prohibition applies regardless of whether the Excluded individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs. Individuals or entities identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality can remain contracted with CalOptima Health as long as the individuals or entities are not listed on a federal or California exclusion list.

a. The responsible department shall deem an Employee, Member of the Governing Body or committee, FDR, non-contracted Provider, or vendor Excluded, or ineligible, if identified on one (1) or more Monitoring sources. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima Health departments of the Excluded, or ineligible, individual, or entity.

b. The responsible department should refer the matter to the Office of Compliance for further investigation. As appropriate, the Office of Compliance may refer issues regarding the Excluded individual or entity to legal counsel for further action.

c. CalOptima Health will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the contractual relationship for all CalOptima Health programs with a FDR, or vendor, or the appointment of a Member of the Governing Body, if such person, or entity, is determined to be Excluded. If the report identifies the removal of a suspended, Excluded, or terminated non-contracted Provider or FDR from CalOptima Health's Provider network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the Provider or FDR is no longer receiving payments in connection with the Medi-Cal program.

d. In the event, that an Employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Employee.

e. CalOptima Health may recoup monies paid to the Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor while Excluded or Precluded. Exclusion and Preclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima Health policy. As appropriate, the Office of Compliance may refer issues regarding the Excluded or Precluded person to legal counsel for further action.

E. Actions Based on Discovery of Individuals/Entities listed in CMS Preclusion List

1. In accordance with Title 42, Code of Federal Regulations, sections 422.222, 422.224, 423.100, 423.120(c)(6), for Precluded Providers, FDRs, or vendors, CalOptima Health may not reimburse or make payment for claims (i.e., for covered items or services) or prescriptions with any individual or entities on the CMS Preclusion List, including for emergency or urgent care circumstances, except for those services outlined in Section II.B.1. of this Policy for Medi-Cal.

a. The responsible department shall deem an FDR, non-contracted Provider, or vendor Precluded if identified on the CMS Preclusion List. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima Health departments of the Precluded FDR, non-contracted Provider, or vendor. CalOptima Health is also to notify the Health Networks to remove any contracted Provider and any contracted pharmacy found on the CMS Preclusion List from their network as soon as possible.

b. CalOptima Health shall notify Precluded FDRs, non-contracted Providers, or vendors in writing that they can no longer treat Members and notify all impacted Members, including Members assigned to Health Networks, in writing who have received care or prescription from the Precluded FDR, non-contracted Provider, or vendor in the last twelve (12) months as soon as possible, but no later than thirty (30) calendar days after the date the FDR, non-contracted Provider, or vendor was Precluded. CalOptima Health will also remove the FDR or vendor from the Provider Directory no later than thirty (30) calendar days after the date the FDR or vendor was Precluded.

c. CalOptima Health will have thirty (30) calendar days to review the CMS Preclusion List and notify in writing impacted Members, including Members assigned to Health Networks, no later than thirty (30) calendar days from the posting of the updated list. Members should be given at least sixty (60) calendar days advance notice before payment denials and claims rejections begin.

d. CalOptima Health should not deny payments and/or reject claims earlier than ninety (90) calendar days after publication of the associated Preclusion list.

e. For FDRs, non-contracted Providers, or vendors identified on both the Exclusion sources and the CMS Preclusion List, CalOptima Health's processes for an Excluded individual or entity supersedes those of a Precluded individual or entity.

F. Actions Based on Discovery of Individuals/Entities listed in the Medi-Cal Restricted Provider Database (RPD)/Procedure/Drug Code Limitation List

1. If CalOptima Health or FDR (as applicable) identifies a Network Provider or Subcontractor listed on the Medi-Cal RPD as a payment suspension, CalOptima Health may continue the contractual relationship, but must withhold reimbursements for Medi-Cal covered services in accordance with Attachment A: Exclusionary Databases and Lists as referenced in DHCS All Plan Letter (APL) 21 – 003: Medi-Cal Network Provider Terminations and Subcontractor Terminations. If CalOptima Health chooses to terminate the contract, it shall submit the appropriate documentation in accordance with Attachment A: Exclusionary Databases and Lists and as outlined in DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider Terminations and Subcontractor Terminations.

2. If CalOptima Health or FDR identifies a Network Provider or Subcontractor listed on the RPD as a temporary suspension, it shall initiate a contract termination and submit appropriate documentation in accordance with Attachment A: Exclusionary Databases and Lists, and as outlined in DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Attachment A).

3. If CalOptima Health or FDR identifies a Network Provider or Subcontractor on the Medi-Cal Procedure/Drug Code Limitation List, CalOptima Health may continue to contract with the Network Provider or Subcontractor but shall not pay for services provided by a restricted provider or receive reimbursement for those services under restriction. If CalOptima Health chooses to terminate the contract, it shall submit appropriate documentation, in accordance with DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Attachment A), including:

a. CalOptima Health's transition plan or narrative description of how CalOptima Health intends to provide Covered Services to affected Members to DHCS in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

b. CalOptima Health's submission of Network Review Documents to DHCS if CalOptima Health is unable to comply with any of the Annual Network Certification (ANC) components as outlined in CalOptima Health Policy GG.1600: Access and Availability Standards.

G. FDRs and Vendors

1. If CalOptima Health intends to deny a prospective FDR or vendor participation in CalOptima Health program(s) or suspend payment (applicable only to Medi-Cal RPD and Medi-Cal Procedure/Drug Code Limitation List), or terminate an existing FDR's or vendor's contract, on the basis of an Exclusion or Preclusion, it shall notify the FDR or vendor, in writing, noting the reason for denial. The prospective or existing FDR or vendor may contest the denial if they feel there is an error or inappropriate Exclusion. If CalOptima Health determines that there is an inappropriate Exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If a previously Excluded or Precluded FDR or vendor has been re-instated by a Monitoring source listed on this Policy and is now in good standing and able to participate in CalOptima Health federal and/or state health care programs, the FDR or vendor may express interest in participating with CalOptima Health. CalOptima Health will require evidence to verify reinstatement into federally funded health care programs. In addition, the FDR or vendor will undergo re-processing through contracting and/or Credentialing.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
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 (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
F. CalOptima Health Policy GG.1304: Continuity of Care during Health Network or Provider Termination
G. CalOptima Health Policy GG.1600: Access and Availability Standards
H. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
I. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
J. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
K. CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised 08/24/2022)
N. Department of Health Care Services All Plan Letter (APL) 23-008: Proposition 56 Directed Payments for Family Planning Services (Supersedes APL 22-011) (Revised 06/27/2023)
O. Medicare Managed Care Manual, Chapter 21
P. Medicare Prescription Drug Benefit Manual, Chapter 9
Q. Medicaid Program Integrity Manual, Revised June 19, 2020
R. Medicare Program Integrity Manual, Chapter 4, Revised July 27, 2020
S. Sections 1128 and 156 of the Social Security Act
T. Title 42, Code of Federal Regulations (CFR), §§422.222, 422.224, 423.100, and 423.120(c)(6)

U. Title 42, Code of Federal Regulations (CFR), §1001.1901
V. Title 42, United States Code (US.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
W. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
07/15/2022	Department of Health Care Services (DHCS)	File and Use
10/17/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Revised	09/01/2015	HH.2021	Exclusion Monitoring	Medi-Cal
Revised	12/01/2016	HH.2021	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2021	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2021	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2021	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2021	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/20/2021	HH.2021	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	06/02/2022	HH.2021	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2021	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare PACE
Revised	08/01/2023	HH.2021	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2021	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 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

Term	Definition
	responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. 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, or Care Coordination, or Coordination of Care as defined in the state Medicaid Agency Contract. PACE: Those items and services provided by CalOptima Health under the provisions of Welfare and Institutions Code, section 14132 and the California State Plan, except those services specifically excluded under Exhibit E, Attachment 1 of the CalOptima Health PACE contract, state law, or the California State Plan.

Term	Definition
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 Practitioner to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Downstream Entity	For purposes of this policy, any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Emergency Services	Medi-Cal: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1). OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity (FTE)	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Governing Body	The Board of Directors of CalOptima Health.

Term	Definition
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.
Monitoring	An on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.