Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/ Michael Hunn 06/20/2024*
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Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners (as described in Section II. of this Policy ("Practitioners")) meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select Practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

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

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

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

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

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

5. CalOptima Health may accept evidence of NCQA Provider Organization Certification (POC) in lieu of a monitoring site visit of delegated physician organization.

C. CalOptima Health may delegate Credentialing and Recredentialing activities to a Health Network or other Delegate in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of Credentialing applications.

1. A Health Network or Delegate shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima Health programs that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities shall include but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving provider files, and ensuring Credentialing policies are adhered to.

E. CalOptima Health CPRC shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima Health.

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

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

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

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

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

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

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

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

H. CalOptima Health shall credential and recredential all contracted practitioners that render services to assigned members, whether the practitioners have a state-level FFS enrollment pathway or not and are:

1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

    a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with DHCS APL 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers (IHCP) and American Indian Members.

    b. CalOptima Health shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those Practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services);

3. Have an independent relationship with the organization;

    a. An independent relationship exists when the organization directs its members to see a specific practitioner or group of practitioners, including all practitioners whom member can select as primary care practitioners; and

4. Provide care to Members under the organization's medical benefits.

I. Credentialing and recredentialing shall apply to Practitioners meeting the criteria in Section II.H. of this Policy, regardless of whether they provide care:

1. In individual or group practices;

2. In facilities; or

3. Through telemedicine/telehealth (i.e., virtual care visit).

J. CalOptima Health shall credential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and do not have an independent relationship with CalOptima Health including:

1. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

    a. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC), Sections 2837.103 and Section 2837.104.

2. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

3. NMPs who are not PAs and who provide services under the employment agreement of a credentialed Practitioner.

K. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity or Organized Health System.

L. For practitioners not required to be credentialed and/or not having a corresponding state-level enrollment pathway, including but not limited to Board Certified Behavioral Analyst (BCBA), CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

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

2. Business licensing that meets industry standards if applicable;

3. History of Fraud, Waste, and/or Abuse;

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

5. History of liability claims against the Practitioner.

M. For the following practitioner types, CalOptima Health shall verify additional qualifications:

1. Doulas must:

a. Comply with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

2. Community Health Workers (CHW) must:

a. Comply with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

3. Board Certified Behavioral Analyst (BCBA) must:

a. Have a valid and current Board Certification in Behavioral Analysis;

b. Not be included in various state, federal, boards, agencies and databanks for adverse activities, in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions; and

c. Have a valid National Provider Identifier (NPI).

N. CalOptima Health may use a signed attestation to validate these qualifications for the practitioner types listed in Section II.M. of this policy.

O. CalOptima Health does not credential or recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management (UM) functions (Credentialing of Pharmacies and its professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy GG.1406: Pharmacy Network Credentialing and Access);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima Health;

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer);

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner; and

7. Students, residents, and fellows, where applicable.

P. CalOptima Health shall recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

Q. CalOptima Health shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall monitor various state, federal, boards, agencies and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

R. CalOptima Health shall notify the Practitioner, in writing, of the Credentialing decision within sixty (60) calendar days of the date of the approval or denial of the application.

S. CalOptima Health shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

T. CalOptima Health shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

U. CalOptima Health shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

V. CalOptima Health shall monitor and prevent discriminatory Credentialing decisions as provided in this Policy.

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

X. CalOptima Health shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

Y. CalOptima Health shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the Credentialing committee.

Z. If CalOptima Health is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

AA. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

BB. CalOptima Health Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Screening and Enrollment

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

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

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

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

    b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a practitioner application (while state law allows DHCS up to one hundred

eight (180) calendar days to act on an enrollment application if the practitioner applies directly to DHCS).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   i. Limited-Risk Practitioners:

      a) Meet state and federal requirements;

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

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

   ii. Medium-Risk Practitioners

      a) Screening requirements of limited-risk practitioners; and

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

iii. High-Risk Practitioners:

a) Screening requirements of medium-risk practitioners; and

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

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

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

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

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

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

i. Additional criteria for high risk practitioners

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

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

Applicant Submission

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

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

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

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

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

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

j. Site Visits

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

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Network Practitioners at least every five (5) years, and their high-risk Network Practitioners every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if practitioners are in compliance with state and federal enrollment requirements.

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

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

b) The practitioner's license was previously suspended;

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

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

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

k. Federal and State Database Checks

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

a) Social Security Administration's Death Master File;

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

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

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Practitioner Initial Credentialing

1. In conjunction with CalOptima Health Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima Health.

a. Upon receipt of the request from the Practitioner, CalOptima Health shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Health Policy GG.1643: Minimum Physician Standards and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that Policy.

c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

d. CalOptima Health shall assess and verify the qualifications of a Practitioner within one hundred eighty days (180) of the date of the signed attestation.

i. CalOptima Health shall assess and verify the qualifications of a Behavioral Health Provider within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

ii. CalOptima Health shall provide written acknowledgement to the Behavioral Health Provider within seven (7) business days of receiving a complete Credentialing application.

iii. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete credentialing application in accordance with APL 24-002 Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members.

e. Practitioners shall attest to:

   i. Any work history gap that exceeds six (6) months, including written clarification;

   ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

   iii. Lack of present illegal drug use that impairs current ability to practice;

   iv. History of criminal convictions;

   v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

   vi. Current malpractice insurance coverage; and

   vii. The correctness and completeness of the application;

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

g. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

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

i. If the required information is not received within ninety (90) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

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

j. An NMP, other than a PA, who does not have an individual relationship with CalOptima Health, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Practitioner.

k. A PA who does not have an individual relationship with CalOptima Health, and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

   i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Practitioner; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

   a. A current, valid California license to practice in effect at the time of the Credentialing decision;

   b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians; and

   c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

3. CalOptima Health shall also collect and verify the following information from each Practitioner as applicable but need not verify this information through a primary source (see Attachment B). This information includes, but is not limited to:

   a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

   b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

      i. History of any suspension or curtailment of hospital and clinic privileges.

      ii. Any alternative admitting arrangements must be documented in the Credentialing file.

   c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS), certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

      i. DEA- and CDS- eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

      ii. Requirement is not applicable for Practitioner who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, however, must describe their process for handling instances when a patient requires a controlled substance.

   d. A valid National Provider Identifier (NPI) number;

e. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision.

i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision.

f. Practitioner information entered in the National Practitioner Data Bank (NPDB), if applicable;

g. No exclusion or preclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect, or abuse, of patients in connection with the delivery of a health care item, or service;

iii. A felony conviction related to health care fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

h. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner, in the last five (5) years;

i. History of state sanctions, restrictions on licensure or limitations on scope of practice, which may include accusations, probation, 805 and 805.1;

j. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

k. Active enrollment status with Medi-Cal, as required;

l. Active enrollment status with Medicare for OneCare as required (i.e., has not Opted-Out of Medicare program): and

m. Active panels with California Children's Services (CCS) Program.

4. CalOptima Health may collect the following information from each Practitioner, as applicable.

a. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable.

C. Practitioner Recredentialing

1. CalOptima Health shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima Health shall:

a. Collect and/or verify, where applicable, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.B of this Policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the Practitioner; and

b. Recredentialing must include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred eighty (180) calendar days before the Recredentialing decision is made.

i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. A review of any Grievances, or quality cases, filed against a Practitioner in the last three (3) years;

iii. Information from quality review activities;

iv. Board Certification, if applicable;

v. Member satisfaction, if applicable;

vi. Medical Record Reviews, if applicable;

vii. FSR results and PARS results, if applicable; and

viii. Compliance with the terms of the Practitioner's contract.

c. All Recredentialing applications must include the same attestation as contained in the practitioner's initial application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima Health terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima Health must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima Health must perform initial Credentialing of such Practitioner.

D. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner rights included in the Addendum A of the credentialing application, as follows:

a. Right to review information

i. Practitioners will be notified of their right to review information CalOptima Health has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

b. Right to correct erroneous information

i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

ii. All Practitioners have the right to correct erroneous information, as follows:

a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

c) All submissions will be mailed to CalOptima Health's Quality Improvement Department using the following address:

Attn: Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima Health's receipt of the identified erroneous information.

3. Right to be notified of application status

a. Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.

b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing and Peer Review Committee (CPRC)

1. CalOptima Health shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files and determining the Practitioner's participation in CalOptima Health programs.

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

    a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than $25,000 paid by, or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

        i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

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

    b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than $25,000, or NPDB query identifying Medical Board investigations, or other actions.

        i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

        ii. CPRC shall give thoughtful consideration to the information presented in the credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

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

4. Provider files identified as not meeting credentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the Chief Medical Officer (CMO), Chair of the CPRC or designee for review.

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

5. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process and shall be verified prior to making a Credentialing decision.

    a. The Quality Improvement Department shall send the Practitioner a decision letter, within sixty (60) calendar days of the decision indicating:

        i. Acceptance;

        ii. Acceptance with restrictions along with Appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

        iii. Denial of the application along with Appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

    b. CalOptima Health shall render a final credentialing decision within one hundred eighty (180) calendar days from the date of the signed attestation that confirms the correctness and completeness of the application.

        i. If CalOptima Health is unable to render a decision within one hundred eighty (180) calendar days from the date of the signed attestation for any Practitioner, during the Practitioner's Credentialing or Recredentialing process, the Practitioner must attest that the information on the application remains correct and complete, by resigning and redating the attestation.

E. CalOptima Health shall monitor and prevent discriminatory practices, to include, but not be limited to:

    1. Monitoring

        a. CalOptima Health shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against as set forth in Section II.U.;

        b. Review Practitioner complaints to determine if there are complaints alleging discrimination; and

        c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

    2. Prevention

        a. The QI Department shall maintain a heterogeneous credentialing committee and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, CalOptima Health Quality Improvement Department shall generate a Practitioner profile and forward the Practitioner profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. This

Practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e., education, training, Board Certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima Health's core business system, which updates pertinent information into the online provider directory.

IV. ATTACHMENT(S)

A. California Participating Physician Application (CPPA)
B. CalOptima Health Primary Source Verification Table
C. Council for Affordable Quality Healthcare Provider Application (CAQH)

V. REFERENCE(S)

A. California Business and Professions Code, §805. §2837.103, §2837.104 and §§3500-3502.3
B. California Evidence Code, §1157
C. California Health & Safety Code § 1374.197
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima Health PACE Program Agreements
H. CalOptima Health Policy GG.1213: Community Health Worker Services
I. CalOptima Health Policy GG.1406: Pharmacy Network: Credentialing and Access
J. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
K. CalOptima Health Policy GG.1604: Confidentiality of Credentialing Files
L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
P. CalOptima Health Policy GG.1619: Delegation Oversight
Q. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
R. CalOptima Health Policy GG.1643: Minimum Physician Standards
S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
T. CalOptima Health Policy GG.1707: Doula Services
U. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
V. CalOptima Health Policy MA.9006: Provider Complaint Process
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit (Revised 12/23/2016)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 08/24/2022)
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-034: California Children's Services Whole Child Model Program (Supersedes APL 21-005)
X. 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
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
V. NCQA Standards and Guidelines

W. Title 42, Code of Federal Regulations (CFR), §§422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days
05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	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
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Medi-Cal: A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. Failure to provide services in a timely manner; or 4. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), sections 41515.2 through 41518.9.
California Children's Services (CCS)-Eligible Condition	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.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization	For purposes of this policy, an organization that collects and verifies credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.

Term	Definition
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).
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that health network.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC section 1603.
Long Term Support Services (LTSS) Provider	For purposes of this policy, a licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	A beneficiary enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.

Term	Definition
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed 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), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502 of the Business and Professions Code and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Physician (PCP).
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to members by referral by other than a Primary Care Physician (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Telehealth	The mode of delivering health care services and public health via 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 the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

Term	Definition
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.