Policy:	EE.1103
Title:	**Provider Network Training**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	*/s/ Michael Hunn 01/29/2025*
Effective Date:	03/01/2001
Revised Date:	01/01/2025
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines the education and training requirements for Newly Contracted Provider and annual training provided by CalOptima Health and its Health Networks to medical, behavioral health, and Long-Term Services and Support (LTSS) Providers (hereinafter referred to as "Network Providers"), any Provider that interacts with CalOptima Health Members and Subcontractors who serve CalOptima Health's Members participating in CalOptima Health Medi-Cal, OneCare and Program of All-Inclusive Care for the Elderly (PACE) programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima Health shall train all CalOptima Health Direct-Administrative and CalOptima Health Community Network participating Network Providers and Subcontractors for Medi-Cal, OneCare and PACE programs in accordance with this Policy.

1. Training will be conducted online or in-person;

2. Training will be reviewed by CalOptima Health's Quality Improvement Health Equity Committee (QIHEC) and Regulatory Affairs and Compliance Department on an annual basis to ensure consistency and accuracy with DHCS requirements and CalOptima Health's policies and procedures; and

3. Records of attendance will be maintained to validate that Network Providers received training on a bi-annual basis.

B. A Health Network shall ensure training of Health Network staff that interact with Members in accordance with this Policy.

1. In compliance with Title 42 Code of Federal Regulations (CFR) Section 438.236(b), CalOptima Health shall ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of CalOptima Health's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, CalOptima Health shall disseminate their practice guidelines to all affected Providers.

C. Network Providers: CalOptima Health or a Health Network shall provide Newly Contracted Provider and annual training to Network Providers who serve CalOptima Health's Members participating in CalOptima Health's health care programs, in accordance with applicable DHCS and CMS requirements and Section III.A. of this Policy.

1. CalOptima Health shall require disability and cultural competency training for its Network Providers in accordance with Section III.C. of this Policy.

2. CalOptima Health shall disseminate practice guidelines to all Network Providers and ensure guidelines are reviewed and updated periodically as appropriate.

3. CalOptima Health shall ensure practice guidelines are based on valid and reliable clinical evidence or a consensus of Network Providers in a particular field and consider the needs of CalOptima Health Members in consultation with Network Providers.

4. CalOptima Health and Health Networks shall develop and implement a process to provide information to Network Providers and to train providers on a continuing basis regarding clinical protocols and evidenced-based practice guidelines and DHCS developed cultural awareness and sensitivity instructions for Seniors and Persons with Disabilities (SPD).

    a. This process shall include an educational program for Network Providers regarding health needs specific to SPD Members that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

    b. Individuals covered by this requirement include, but are not limited to, CalOptima Health and Health Network staff that interact with Members, as applicable, contracted CalOptima Health and Health Network Primary Care Physicians (PCPs), specialists who serve a high-volume of SPD Members, and speech, occupational, and physical therapists, in accordance with Welfare and Institutions Code section 14182(b)(5).

5. CalOptima Health and Health Networks shall develop and disseminate annual diversity, health equity and inclusion training related to Members including completion of required Continuing Medical Education on cultural competency and implicit bias.

D. Designated County Agencies: CalOptima Health shall provide training to staff of partner designated county agencies interacting with Members, as applicable, and in accordance with Section III.B.1. of this Policy.

E. For Out-of-Network Providers who will not receive Network Provider training, CalOptima Health or a Health Network shall develop and implement a process to provide the Out-of-Network Provider with grievance processes, clinical protocols, evidence-based practice guidelines, and the Special Needs Plan (SNP) Model of Care. CalOptima Health or a Health Network shall arrange to provide these protocols and guidelines at the time that CalOptima Health or a Health Network enters into an agreement with an Out-of-Network Provider.

1. CalOptima Health shall require disability and cultural competency training for its Network Providers in accordance with Section III.C. of this Policy.

F. PACE Providers shall complete training prior to commencement of services to PACE Participants.

G. CalOptima Health shall review Health Network reports to ensure compliance with Newly Contracted Provider and annual training.

H. CalOptima Health and each Health Network shall make a Provider Manual accessible to all Network Providers and Subcontractors.

I. Training attestations shall be required as provided in Sections III.E-F. of this Policy.

J. CalOptima Health and Health Networks shall ensure that Network Providers and Subcontractors complete the self-registration process, are trained on how to operate the Electronic Visit Verification (EVV) system and have gained access to the state-sponsored EVV system and EVV Aggregator as outlined in Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements.

    1. CalOptima Health and Health Networks shall supply Network Providers with technical assistance and training on EVV compliance.

K. CalOptima Health shall ensure the required DHCS Dementia Care Aware Cognitive Health Assessment training is completed prior to conducting annual cognitive assessments for Medi-Cal Members as outlined in the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older.

    1. CalOptima Health shall ensure that Network Providers have completed the required training prior to claim submission and payment.

L. CalOptima Health and Health Networks shall ensure Network Providers complete Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) training no less than every two (2) years, in accordance with DHCS APL 23-005: Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21.

    1. At minimum, CalOptima Health and Health Networks shall use the training program developed by DHCS to promote a more uniform and shared understanding of the EPSDT benefit. The training program refers to EPSDT as Medi-Cal for Kids & Teens.

    2. On an annual basis, by February 15th of each calendar year, CalOptima Health shall submit a comprehensive plan to DHCS ensuring all Network Providers receive proper education and training regarding EPSDT.

        a. The annual comprehensive plan shall include an attestation that the Provider Network is in compliance with the EPSDT training requirements and include a list of Network Providers who have completed training within the past twelve (12) months.

        b. The annual comprehensive plan shall include how many Network Providers serve Members under the age of twenty-one (21), how many Network Providers are not in compliance, and an outline of the steps CalOptima Health has taken to ensure Network Providers are fully compliant.

    3. If CalOptima Health chooses to augment the training with additional information, CalOptima Health shall submit training materials with edits highlighted to DHCS for review and approval prior to use.

M. CalOptima Health and Health Networks shall ensure Network Providers, Subcontractors and Downstream Subcontractors are trained on complying with valid Advance Directives, in accordance with 42 CFR Sections 422.128 and 438.3(j).

N. CalOptima Health shall pay all claims within contractually mandated statutory timeframes in accordance with CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible, DHCS APL 23-020: Requirements for Timely Payment of Claims.

1. Network Providers have an obligation to refrain from billing Members for Covered Services, even if CalOptima Health pays late or denies payment for a claim.

O. CalOptima Health shall be responsible for ensuring Subcontractors and Network Providers comply with all appliable state and federal laws and regulations, contract requirements and other DHCS guidance, including APLs, related Policy Guides and Policy Letters in accordance with DHCS APL 23-030: Medi-Cal Justice-involved Reentry Initiative-related State Guidance.

1. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance.

P. For purposes of this policy, the Newly Contracted Provider training and annual training are referred to as separate and distinct trainings due to the timeframe requirements for each training. The content included in the Newly Contracted Provider training and annual training is the same.

III. PROCEDURE

A. Newly Contracted Provider Training

1. Newly Contracted Provider and Annual Training for Network Providers shall be provided as follows:

a. CalOptima Health or Health Network shall initiate training for all Network Providers and Subcontractors no later than ten (10) business days and shall complete the training within thirty (30) calendar days of placing them on Active Status.

b. Training materials shall include, but are not limited to the following:

i. Training presentation; and

ii. Training attestation.

2. Health Networks shall attest that appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness and sensitivity instructions for SPDs in accordance with Welfare and Institutions Code section 14182(b)(5).

3. CalOptima Health shall provide training on key elements of operating a successful program for administering Managed Long-Term Services and Supports (MLTSS).

4. Upon completion of the training, the Network Provider and other staff deemed appropriate by CalOptima Health shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima Health or the Health Network.

5. If CalOptima Health or a Health Network is unable to complete the training within the thirty (30) calendar day requirement, CalOptima Health or Health Network shall send materials to the Network Provider’s office, and document reasons and actions taken due to non-completion of the training.

6. CalOptima Health and its Health Networks shall track completion of the Network Provider's training, including the date of completion of the training.

7. CalOptima Health or a Health Network shall retain training records for a period of at least ten (10) years.

B. Network Provider and Subcontractor Annual Training

1. CalOptima Health or Health Networks shall provide annual training for Network Providers and Subcontractors:

a. Annual training required one time per year;

b. When conducting Provider forums, meetings, outreach visits;

c. When determined necessary through notification to Providers of newly contracted product lines or updates to existing product services, performance data, such as complaint and grievance data, Member and Provider satisfaction and accessibility surveys, and practices serving a high volume of targeted populations;

d. Upon request from Providers; and

e. When CalOptima Health or one of its regulators determines that a Provider has discriminated against a CalOptima Health Member.

C. Newly Contracted Provider Training and Annual Training Material

1. As specified in Attachment A, Newly Contracted Provider training and annual training will include, but not limited to:

a. CalOptima Health programs and initiatives, including but not limited to, the California Advancing and Innovating Medi-Cal (CalAIM) and the Whole-Child Model (WCM) program;

b. CalOptima Health/Health Network operations;

c. Provider communications;

d. Member rights and responsibilities;

e. CalOptima Health policies and procedures;

f. Individual Health Education Behavioral Assessment (IHEBA) contract requirements;

g. Member benefits;

h. Claims submission, including what constitutes a clean claim or an acceptable Encounter, and payment;

i. Coordination of benefits, covered services and carved-out services;

j. Conflict resolution;

k. Critical incident reporting;

l. Member Grievance and Appeals process and requirements for Network Providers and Out-of-Network Providers;

m. Member billing restrictions;

n. Utilization Management Appeals and Provider dispute resolution process;

o. Prior authorization process;

p. Medical management and authorization requirements;

q. Customer service and cultural linguistic requirements

r. Community Based Adult Services;

s. Behavioral Health;

t. Medical management delegation and payment responsibility;

u. Medi-Cal and Medicare Member eligibility verification and disenrollment process;

v. Seniors and Persons with Disabilities (SPD) trainings;

w. Fraud, Waste, and Abuse and compliance training;

x. Model of Care;

y. Access standards;

z. Long-Term Support Services (LTSS);

aa. Authorizations, claims and Member eligibility verification process for hospitals, skilled nursing facilities and ancillary providers;

bb. Disability training information, including, but not limited to, the following:

    i. Members with chronic conditions prevalent within the population;

    ii. Awareness of personal prejudices;

    iii. Legal obligations to comply with Title II of the Americans Disability Act (ADA) and Section 504 of the Rehabilitation Act;

    iv. Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs;

    v. Types of barriers encountered by the target population;

vi. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles, and the recovery model;

vii. Working with Members with mental health diagnoses and specialty mental health service's needs, including crisis prevention and treatment;

viii. Working with Members with substance use disorder conditions, including diagnosis and treatment;

ix. Working with Members with Intellectual and Developmental Disabilities;

x. Working with Children with Special Health Care Needs (CSHCN); and

xi. HIV stigma and non-discrimination requirements.

cc. Quality improvement for health services programs;

dd. Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+) cultural competency training;

ee. Use of culturally competent practices including, but not limited to:

i. Diversity, Equity and Inclusion (DEI) training;

ii. Structural and institutional racism and health inequities training including the impact on Members, staff, Network Providers, Subcontractors and Downstream Subcontractors;

iii. Access and delivery of services in a culturally competent manner for all Members regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and

iv. Health inequities and identified cultural groups including:

a) Cultural group's belief about illness and health;

b) Need for gender affirming care;

c) Methods of interacting with Providers and the health care structure;

d) Traditional home remedies and impacts of patient treatment; and

e) Language and literacy needs.

v. Pertinent information regarding Population Needs Assessment (PNA) findings and identified targeted areas.

ff. Use of clinical practice guidelines, clinical protocols, evidence-based practices, and specific levels of quality outcomes;

gg. Electronic Visit Verification Requirements and Reporting;

hh. Doula services;

ii. Dementia care aware cognitive health assessment training;

jj. Early Periodic Screening, Diagnosis and Testing (EPSDT) training;

kk. Responsibilities for Indian Health Care Providers and American Indian Members including:

i. Cultural Humility training;

ii. Overview of Trauma-Informed Care and Historical Trauma training; and

iii. Other relevant trainings as they are developed and noted by DHCS.

D. Provider Manual Requirements

1. CalOptima Health or a Health Network shall make a Provider Manual accessible to all Network Providers, Subcontractors, and Downstream Subcontractors. The Provider Manual shall include, at a minimum, the following information:

a. Updates and revisions;

b. Overview and Model of Care;

c. CalOptima Health or Health Network contact information;

d. Member benefits covered by CalOptima Health;

e. Eligibility determination and verification process;

f. Quality improvement for health services programs;

g. Member rights and responsibilities;

h. Provider billing and reporting;

i. The Member problem resolution process;

j. The authorization process;

k. Provider cultural and linguistic requirements;

l. Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than twenty-one (21) years of age;

m. Medical Record documentation and coding requirements;

n. Regulatory and contractual requirements;

o. Vaccines for Children (VFC);

p. Other activities and services needed to assist Members in optimizing their health status, including assistance with self-management skills or techniques, preventative healthcare services, health education, and other modalities to improve health status; and

q. Provider liaison requirements as specified in Attachment B.

E. Health Network Training Materials

1. By or before January 15 of each year, Health Networks shall attest that all Health Network Providers participating with CalOptima Health and Health Networks, have completed, attested, and retained such records of Newly Contracted Provider and Annual Training located on CalOptima Health's website www.caloptima.org. Training materials to include the following:

a. Cultural Competency Training;

b. Disability Awareness Training;

c. OneCare Model of Care; and

d. Fraud, Waste and Abuse Training.

F. Training Attestations Requirements

1. Training attestations are required for:

a. Health Networks, Network Providers, Subcontractors, and all personnel that completed CalOptima Health's training.

i. All staff who interact or potentially interact with Medi-Cal, OneCare Members, and SPD beneficiaries;

ii. All staff who are responsible for policies and procedures affecting Medi-Cal, OneCare members and SPD beneficiaries; and

iii. Any other staff deemed appropriate by CalOptima Health and CMS.

b. A Health Network, Network Provider or Subcontractor shall provide the following information on the training attestation:

i. Organization name;

ii. Date of completed training;

iii. Name of individual attesting; and

iv. Signature of individual attesting.

c. CalOptima Health Provider Relations Department shall validate that the following requirements are met:

i. Training for all Network Providers is initiated no later than ten (10) business days after CalOptima Health places a newly contracted Network Provider on Active Status and completed within thirty (30) calendar days of placing on Active Status;

ii. A signature of individual attesting; and

iii. Health Networks shall submit Newly Contracted Provider and annual training reports pursuant to CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting. The Newly Contracted Provider and annual training reports on the reporting grid reflect the reporting submission requirements.

G. Health Network and Delegated Entity Reporting

1. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima Health as required by CalOptima Health or as specified in its contract or CalOptima Health's policies and procedures in accordance with CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting. Reporting requirements shall include:

   a. Data Element Reporting requirements and/or Subcontract Network Certification requirements.

2. CalOptima Health Provider Relations Department shall be accountable for:

   a. Identifying required reports;

   b. Ensuring that all reports list all applicable regulatory, contractual, and policy citations and include all required data elements;

   c. Creating templates and all applicable reporting formats, instructions, and technical guidelines;

   d. Monitoring submission and timeliness of reports;

   e. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

   f. Notifying Health Network Relations of unsuccessful follow-up attempts; and

   g. Escalating issues of continued noncompliance to the Office of Compliance.

3. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Health's Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

4. The Office of Compliance shall be responsible for the annual audit of CalOptima Health and Health Networks provider training in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

H. Verification of Network Provider Training

1. CalOptima Health and Health Networks shall verify that Network Providers attest to the Newly Contracted Provider and annual training.

2. Verification

a. On an annual basis, CalOptima Health shall obtain Newly Contracted Provider and annual training attestations from Health Networks and CalOptima Health Community Network (CHCN).

b. Health Networks and CHCN shall document the outcome of each attempt to obtain Newly Contracted Provider and Annual Training attestations.

c. CalOptima Health shall monitor training attestation compliance annually in accordance with this Policy.

IV. ATTACHMENT(S)

A. Provider Network Training Descriptions
B. Provider Liaison Requirements

V. REFERENCE(S)

A. Annual Provider Training: https://www.caloptima.org/en/ForProviders/ProviderTrainings
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy GG.1619: Delegation Oversight
F. CalOptima Health Policy HH.2002: Sanctions
G. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
H. CalOptima Health Policy HH.2005: Corrective Action Plan
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection For Members With Visual Impairments
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
N. Department of Healthcare Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031)
O. Employee SNP Model of Care Training: https://www.caloptima.org/en/ForProviders/ProviderTrainings
P. Medicare Managed Care Manual, Chapter 5, Section 20.2.2, MOC 3, Element C, Factors 1 and 2
Q. Newly Contracted Provider Office Education Training: https://www.caloptima.org/en/ForProviders/ProviderTrainings
R. Title 42, Code of Federal Regulations (CFR), §§422.101(f)(2)(ii), 422.128, 438.3(u), 438.206(c)(2), 438.236(c), 438.3(j) and 438.414
S. Welfare and Institutions (W&I) Code, §14182 (b)(5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/29/2010	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted

Date	Regulatory Agency	Response
03/01/2022	Department of Health Care Services (DHCS)	Approved as Submitted
03/29/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/07/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/30/2024	Department of Health Care Services (DHCS)	File and Use
12/16/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
02/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2001	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	07/01/2007	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	01/01/2009	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	11/01/2012	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	03/01/2015	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2015	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2016	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	06/04/2020	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	02/03/2022	EE.1103	Provider Network Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2022	EE.1103	Provider Network Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	03/01/2023	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	10/01/2023	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	12/01/2023	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	05/01/2024	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	11/01/2024	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	01/01/2025	EE.1103	Provider Network Training	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with CalOptima Health, or a Health Network. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within that group.
Advance Directives	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
California Advancing and Innovating Medi-Cal (CalAIM)	A multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Direct Administrative (COHD-A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members who meet certain eligibility criteria as described in CalOptima Health Policy DD.2006 Enrollment in/Eligibility with CalOptima Health Direct.

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Children with Special Health Care Needs (CSHCN)	Children with Special Health Care Needs (CSHCN): Children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CSHCN shall comply with the requirements of 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).
Chronic Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Community Based Adult Services (CBAS)	Offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.
Critical Incident	Critical incident refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Department of Health Care Services (DHCS)	A department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs.
Delegated Entity	For purposes of this policy, a Delegated Entity is contracted with CalOptima Health to provide covered services to eligible CalOptima Health Members including but not limited to medical, dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Health Members.
Developmental Disability (DD)	A disability, which originates before the individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, Section 4512(a).
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of

Term	Definition
	health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. 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.
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), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Intellectual Disability (ID)	A condition manifested before the person reaches age twenty-two (22) and results in impairment of general intellectual functioning or adaptive behavior and significant limitations in at least three (3) or more of the following areas: communication, self-care, home living, social skills, use of community resources, self-direction, understanding and use of language, learning, mobility, capacity for independent living.
Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+)	For purposes of this policy, LGBTQIA+ is an acronym for Members that identify as lesbian, gay, bisexual, transgender and queer and/or questioning, intersex, and asexual.
Long Term Services and Supports (LTSS)	Medi-Cal: A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled nursing facility services and subacute care services; and 4. In-Home Supportive Services (IHSS). OneCare: A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following: 1. Community Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled nursing facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.

Term	Definition
	OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	A beneficiary enrolled in a CalOptima Health program.
Network Provider	For purposes of this policy, a Provider that is contracted with CalOptima Health or a Health Network contracted with CalOptima Health for the delivery of Medi-Cal covered services.
Newly Contracted Provider	For purposes of this policy, a Provider that is newly contracted ten (10) days after active status with CalOptima Health or a Health Network contracted with CalOptima Health for the delivery of Medi-Cal covered services.
Out-of-Network Provider	A Provider that does not participate in CalOptima Health's Network.
Participant	An individual enrolled in the CalOptima Health PACE program.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
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.
Quality Improvement Health Equity Committee (QIHEC)	The CalOptima Health committee that is responsible for the Quality Improvement (QI) and Health Equity process.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

Term	Definition
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.
Threshold Language	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.