



**NOTICE OF A
SPECIAL MEETING OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE**

**THURSDAY, OCTOBER 15, 2026
3:00 P.M.**

**505 CITY PARKWAY WEST
ORANGE, CALIFORNIA 92868**

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE

Maura Byron
Catherin Green, R.N.
(Vacant)

**CHIEF EXECUTIVE OFFICER
Michael Hunn**

**OUTSIDE GENERAL COUNSEL
James Novello
Kennaday Leavitt**

**CLERK OF THE BOARD
Tina Knapp**

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form identifying the item and submit it to the clerk. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors, you may do so during Public Comments. When addressing the Committee, it is requested that you state your name for the record. Address the Committee as a whole through the Chair. Comments to individual Board Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

In compliance with the Americans with Disabilities Act, those requiring accommodations for this meeting should notify the Clerk of the Board's Office at (714) 246-8806, at least 72 hours prior to the meeting.

The Board of Directors' Quality Assurance Committee Meeting Agenda and supporting materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. - 5:00 p.m. These materials are also available online at www.caloptima.org.

Your participation is always welcome. Specific information as to how to participate in this meeting is detailed in the Notice Regarding Public Attendance & Participation at Public Meetings attached to this agenda. In general, CalOptima Health offers several ways in which to interact during this meeting: you may participate in person, join the meeting live on your computer or similar device, and/or listen to the meeting via telephone.

CALL TO ORDER

Pledge of Allegiance
Establish Quorum

PRESENTATIONS

None.

ADVISORY COMMITTEE UPDATES

1. **Program of All-Inclusive Care for the Elderly Member Advisory Committee Update**
2. **Whole-Child Model Family Advisory Committee Updates**

PUBLIC COMMENTS

At this time, members of the public may address the Committee on matters not appearing on the agenda, but within the subject matter jurisdiction of the Committee. Speakers will be limited to three (3) minutes.

CONSENT CALENDAR

3. **Approve Minutes of the June 18, 2026 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee**

DISCUSSION ITEMS

4. **Approve the CalOptima Health Measurement Year 2027 Medi-Cal and OneCare Pay for Value Programs**

Recommended Action: Recommend that the Board of Directors:

1. Approve CalOptima Health Measurement Year 2027 Medi-Cal Delegated Health Network Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
2. Approve CalOptima Health Measurement Year 2027 OneCare Delegated Health Network Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
3. Approve the Measurement Year 2027 CalOptima Health Community Network Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
4. Approve the Measurement Year 2027 Shared Risk Pool Quality Measures effective January 1, 2027, through December 31, 2027.

5. **Approve the Measurement Year 2027 CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program**

Recommended Action: Recommend that the Board of Directors:

Approve the Measurement Year 2027 Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program, effective January 1, 2027, through December 31, 2027.

6. Approve the CalOptima Health Calendar Year 2027 Member Health Rewards Program

Recommended Action: Recommend that the Board of Directors:

Approve the CalOptima Health Calendar Year 2027 Member Health Rewards Program for Medi-Cal and OneCare, effective January 1, 2027, through December 31, 2027.

7. Approve Actions Related to Implementation of a Quality Improvement Grant Pilot Program

Recommended Action: Recommend that the Board of Directors:

1. Authorize CalOptima Health staff to conduct a non-competitive, by-invitation-only, notice of funding opportunity related to the Quality Improvement Grant Pilot Program, administer grant agreements, and release award payments to participating entities.
2. Authorize allocation of up to \$500,000 from the CalOptima Health Community Care Network component of the Measurement Year 2025 Pay-for-Value Program for the Quality Improvement Grant Pilot Program.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

8. Approve New CalOptima Health Policy: GG.1640 and Approve Modifications to CalOptima Health Policies: GG.1611, GG.1615, GG.1616, GG.1650, and GG.1651

Recommended Action: Recommend that the Board of Directors:

Approve CalOptima Health Policy GG.1640: Health Network Pay for Value (P4V) Program, a new policy establishing the quality incentive framework for CalOptima Health Networks participating in Medi-Cal, OneCare, and Covered California, and approve the revisions to the following existing CalOptima Health policies:

Policy GG.1611: Potential Quality Issue Review Process

Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues

Policy GG.1616: Fair Hearing Plan for Licentiates

Policy GG.1650: Credentialing and Recredentialing of Practitioners

Policy GG.1651: Assessment and Reassessment of Organizational Providers

INFORMATION ITEMS

9. Quality Improvement Program Updates

- A. Measurement Year 2025 Healthcare Effectiveness Data and Information Set (HEDIS®) Results
- B. Quality Improvement Program Updates
- C. Utilization Management Update
- D. Member Grievances and Appeals Report

10. Grant Management Activities & Updates

11. Quarterly Reports to the Quality Assurance Committee

The following reports are included for informational purposes only. No action is required on these items.

- A. Quality Improvement Health Equity Committee Report
- B. PACE Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT



**NOTICE REGARDING
PUBLIC ATTENDANCE & PARTICIPATION AT PUBLIC MEETINGS
Board of Directors' Quality Assurance Committee Meeting
Thursday, October 15, 2026
3:00 p.m.**

Your participation is always welcome. CalOptima Health offers several ways in which to interact during meetings. You will find information as to these opportunities below.

IN-PERSON MEETING ATTENDANCE

You may attend the meeting in-person at the following location:

CalOptima Health
505 City Parkway West
Orange, CA 92868

LIVE AUDIO & VIDEO STREAMING (INCLUDING PUBLIC COMMENT CAPABILITY)

You may join the meeting live on your computer or similar device by using the link below:

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Passcode: 389533

*For any questions, please contact the CalOptima Health Clerk of the Board's office at
714-246-8806. Thank you for your interest in CalOptima Health!*



Board of Directors' Quality Assurance Committee Meeting October 15, 2026

PACE Member Advisory Committee Update

Committee Overview

The PACE Member Advisory Committee (PMAC) meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima PACE leadership on the PACE care delivery system. The committee is primarily comprised of PACE participants.

June 17, 2026: PMAC Meeting Summary

Updates from the Director

Director Monica Macias thanked PMAC members for joining the meeting in person. Members were updated on the status of the program, open positions, transportation and scheduling. The Director welcomed new members who were joining us for the first time. Director updated the group on additional support for transportation services that may be joining our team. The focus for this transportation vendor will be dialysis trips only at this time. Director also shared news around our growth and mentioned that CalOptima Health PACE has initiated the process to the state for a potential second location. The second location has been identified, and we are currently in the process of acquiring the building. Participants also shared the continued challenges with transportation and outside appointments. Director mentioned that adding the second vendor will help with the trips and support the growth. In addition, PACE is also working with the external specialists to improve communication and educate them on the PACE model of care. We will continue to work on these initiatives and efforts.

Participants acknowledged the upcoming changes and are looking forward to improvements. They continue to express excitement regarding a second location to help and support more participants in our community.

PMAC Member Forum

- Director will continue to support participants regarding external specialist visits and follow up at our next PMAC meeting to see how things are going.
- Participants will continue to have an opportunity to share feedback, concerns or compliments at our PMAC meetings.
- Participants expressed gratitude with the care and attention they receive while they are at PACE.



Board of Directors’ Quality Assurance Committee Meeting October 15, 2026

Regular Meeting of the Whole-Child Model Family Advisory Committee Report to the Quality Assurance Committee

On August 18, 2026, the Whole-Child Model Member Family Advisory Committee (WCM FAC) held its quarterly meeting, which was conducted both in person and via Zoom Webinar.

The committee welcomed Yvette Lavery, a consumer advocate on the WCM FAC, appointed by the Board on August 6, 2026.

Dr. Michelle Laba of California Children’s Services (CCS) provided an update on CCS’s participation in the Whole Child Model’s annual provider training, noting ongoing coordination to support statewide alignment. She also reported on recent enhancements to the CCS phone tree and described continued collaboration with voice engineering teams to resolve remaining technical issues.

Dr. Laba noted that recruitment efforts for CCS Medical Therapy Conference physicians had begun, prompted by recent succession needs and staff attrition. She emphasized the importance of maintaining adequate medical staffing to support program operations. Dr. Laba also discussed a statewide overview that was presented, covering active work groups focused on CCS aid codes, NICU and high-risk infant follow-up referral processes, and improvements to transitions for children with unsatisfactory immigration status. She noted that each of these work streams aims to strengthen consistency and support across counties.

Additionally, Dr. Laba informed the committee that CCS facility approvals in Orange County have advanced, including the approval of Rady’s Children’s Rehabilitation Communications Disorder Center in Irvine.

Kelly Giardina, Executive Director, Medical Management and Clinical Operations, and Michael Gomez, Executive Director, Network Operations, provided an overview of the primary care physician (PCP) incentive pilot focused on the age-out transition within the Whole Child Model. The pilot aims to improve continuity of care and reduce disruptions as CCS Whole Child Model members transition to adult care settings. Ms. Giardina noted that early transition activities begin about six months before a member turns 21 to support structured warm handoffs between pediatric and adult providers. She also

highlighted that the pilot received approval at the August Board of Directors meeting and emphasized engagement with multiple stakeholder groups throughout the planning and implementation phases.

Michael Gomez outlined the contracting and onboarding strategy, including a provider identification survey and a practical playbook that guides participating practices through pilot workflows and expectations.

Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal and CalAIM, provided an update on the Community Reinvestment Plan, explaining that Medi-Cal health plans must reinvest a portion of their net income in the community in line with health equity principles. Dr. Bruno-Nelson outlined the plan's key focus areas, including strengthening behavioral health infrastructure, expanding healthcare workforce development, and supporting housing and homelessness services. She also described the next steps, including submitting the plan to DHCS and making initial investments once it is approved.

During the discussion, a family member shared personal concerns about rising rents and the strain they place on her family. Michael Hunn, Chief Executive Officer, acknowledged these challenges and noted ongoing conversations with the Board to explore ways to address housing-related issues and broader community needs.

Yunkyung Kim, Chief Operating Officer, provided an update on the upcoming transition of CCS members with unsatisfactory immigration status to the fee-for-service system, effective January 1, 2027. This change will affect approximately 300 Whole-Child Model children, making close coordination with the CCS program essential to ensure continuity of care. Ms. Kim highlighted several challenges, including the importance of warm handoffs and potential effects on providers. She added that a high-touch approach will support members throughout the process and noted that CCS partners are actively developing the transition plan.

Richard Lopez, M.D., Interim Chief Medical Officer, emphasized the importance of the primary care physician age-out transition program. A family member raised concerns about finding a pediatrician who understands her son's needs, prompting Dr. Lopez and Michael Gomez to discuss the complexities families face when transitioning from pediatric to adult care. CalOptima Health Board Member Maura Byron, who was in attendance, recommended that parents begin transition planning early by initiating conversations with specialists. Chair Lori Sato shared positive experiences with Rady's A2B clinic, noting its valuable support for families navigating this transition.

Veronica Carpenter, Chief Administrative Officer, thanked the committee members for sharing their experiences and for the value of hearing firsthand from families about what they encounter in their daily lives. She then provided several high-level updates. At the federal level, CalOptima Health is awaiting the final CMS rule on the community engagement requirement related to HR 1, last year's Medicaid reform bill that added eligibility requirements to reduce the Medi-Cal population. Ms. Carpenter noted that CalOptima Health submitted a comment letter and is working closely with associations to address medically frail exemptions. Additional information will be shared once the rule is released.

At the state level, she reported that the legislative session is in its final week, with both houses holding marathon floor sessions. Any bill not passed by midnight Monday will not advance. She also highlighted

a governance bill authored by Assemblymember Avelino Valencia that would stagger board member terms and initiate an audit of CalOptima Health's governance practices. She stated that the bill is expected to pass both houses and reach the governor before the deadline. Ms. Carpenter also addressed Chair Lori Sato's question about Assembly Bill 2486, authored by Assemblymember Dawn Addis, which would extend the timeline for the statewide CCS Advisory Group's integration with the Whole Child Model group and add categorical seats. The bill has been removed from the suspense file, is queued for a Senate floor vote, and is expected to pass the week of August 24, 2026.

Michael Hunn, Chief Executive Officer, discussed the transition challenges facing Whole-Child Model (WCM) members and warned that the unsatisfactory immigration-status transition will be difficult, largely because physicians are reluctant to accept fee-for-service patients. He anticipated that reimbursement rates would drop from 200% to 100% of the Medi-Cal schedule, making it harder to secure providers.

Mr. Hunn also discussed how the new Medi-Cal rules now require twice-yearly redetermination and that staffing shortages at the Social Services Agency will worsen the situation. Many members have already lost coverage, and 114,000 more are expected to lose access, risking disruptions in care and medication. He noted that CalOptima Health is preparing communications but will lose oversight and care management after January, and that reliance on a nurse advice line may not meet complex needs. He emphasized that maintaining continuity of care is vital, especially for WCM members, and that community clinics and philanthropic support are crucial. CalOptima Health expects a \$700–750 million annual budget reduction that will impact Orange County's healthcare environment, and that strong communication is essential. He encouraged the committee members to share concerns to help shape CalOptima Health's response.

The WCM FAC appreciates the opportunity to provide input and updates on its current activities and thanks CalOptima Health's Board of Directors' Quality Assurance Committee for the opportunity.

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS’
QUALITY ASSURANCE COMMITTEE

June 18, 2026

A Regular Meeting of the CalOptima Health Board of Directors’ (Board) Quality Assurance Committee (Committee) was held on June 18, 2026, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar. The meeting recording is available on CalOptima Health’s website.

Chair Jose Mayorga called the meeting to order at 3:21 p.m., and Director Cathy Green led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Jose Mayorga, M.D., Chair; Maura Byron; and Catherine Green, R.N.
(All Committee members participated in person.)

Members Absent: None.

Others Present: Linda Lee, Executive Director, Quality Improvement; Kelly Giardina, Executive Director, Clinical Operations; Dr. Robin Hatam, Medical Director; Dr. Zeinab Dabbah, Deputy Chief Medical Officer; Dr. Kelly Bruno-Nelson, Executive Director, CalAIM; Yunkyung Kim, Chief Operating Officer; Veronica Carpenter, Chief Administrative Officer; Heather Sedillo, Director, GARS; Ruby Nunez, Executive Assistant; Samantha Pellón, Vice President, Chapman Consulting; Gretchen Nye, Director, Chapman Consulting; and Lori Sato, Chair, Whole-Child Model Family Advisory Committee.

ADVISORY COMMITTEE UPDATES

1. Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee Update

Monica Macias-Garcia, Director, CalOptima Health PACE, provided a brief update of the PACE Member Advisory Committee (PMAC) activities that included the recent Electronic Medical Record (EMR) transition and the continued confusion by PACE participants surrounding coordination of external provider appointments. Ms. Macias-Garcia also described ongoing challenges with external providers who occasionally overlook PACE’s role due to its smaller footprint in Orange County, requiring continued outreach and clarification. She also noted patients’ enthusiasm for the potential expansion to a second location, expressing gratitude for current support and noting that the participants have expressed to her that the program feels increasingly full. Ms. Macias-Garcia stated that of the 582 participants enrolled in PACE, the center sees about 145 participants per day.

2. Whole-Child Model Family Advisory Committee (WCM FAC) Update

Lori Sato, Chair, WCM FAC, provided highlights from the May 19, 2026, meeting. She reported that the WCM FAC received several program updates and discussed issues affecting WCM FAC families.

Chair Mayorga thanked Ms. Sato for her service and contributions to the WCM FAC.

PUBLIC COMMENTS

None.

CONSENT CALENDAR

3. Minutes

- a. Approve the Minutes of the March 19, 2026, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Action: *On motion of Director Byron, seconded by Director Green, the Committee approved the Consent Calendar as presented.*

AYES:	Jose Mayorga, Chair; Maura Byron; and Catherine Green
NOES:	None
ABSENT:	None
ABSTENTION:	None
RECUSALS:	None

Michael Hunn, Chief Executive Officer, expressed deep appreciation for Dr. Mayorga as he concluded his service on both the Committee and the Board.

REPORTS/DISCUSSION ITEMS

4. Recommend that the Board of Directors Approve Modifications to CalOptima Health Policy: GG.1611

Linda Lee, Executive Director, Quality Improvement, provided a high-level overview of the modifications to CalOptima Health Policy GG.1611: Potential Quality Issues Review Process, explaining that the policy now includes expanded language clarifying Business & Professions Code sections 805 and 805.01 reporting requirements for serious quality issues; and aligning the procedure with Centers for Medicare & Medicaid Services, Department of Health Care Services (DHCS), and state licensing board regulations. She also noted that the potential quality issue case closure timeframe has been extended from 90 days to 120 days, consistent with industry standards and current Medi-Cal plan operations.

Ms. Lee further clarified that the policy now requires the closing a quality-of-service case without physician review requires two registered nurse reviewers, ensuring consistency and alignment with established quality improvement processes. Lastly, she reported that the policy's quality inbox has been updated for greater clarity, replacing individual contacts with a centralized communication point.

Action: *On motion of Director Green, seconded by Director Byron, the Committee recommended that the Board of Directors approve modifications to CalOptima Health Policy GG.1611: Potential Quality Issue Review Process in connection with CalOptima Health's regular review process and consistent with regulatory requirements.*

AYES: Jose Mayorga, Chair; Maura Byron; and Catherine Green
NOES: None
ABSENT: None
ABSTENTION: None
RECUSALS: None

5. Recommend that the Board of Directors Approve Reallocation of Remaining Non-monetary Gift Cards

Ms. Lee explained that in November 2022 the Board approved physical Target gift cards for member vaccination incentives during the COVID-19 emergency, and later for the OneCare preventative and wellness services in November 2023. She noted that CalOptima Health has since transitioned OneCare rewards to flex benefit digital cards, leaving a remaining inventory of approximately 2,600 physical cards. She stated that the action before the Committee was to seek approval to repurpose the cards for the already Board-approved 2026 Member Health Rewards Program, using them to support annual wellness visits, breast cancer screenings, and chronic disease-related services. Ms. Lee emphasized that the cards cannot be used for any other purpose because they were originally allocated for specific member incentive programs and that this reuse would allow CalOptima Health to responsibly draw down the inventory across the current and upcoming year.

Action: *On motion of Director Byron, seconded by Director Green, the Committee recommended that the Board of Directors:*

- 1. Approve the reallocation of the remaining non-monetary gift cards totaling \$16,425 from the Medi-Cal COVID-19 Member Vaccination Incentive Program to the Calendar Year 2026 Medi-Cal Member Health Rewards Program.*
- 2. Approve the reallocation of the remaining non-monetary gift cards totaling \$2,750 from the OneCare COVID-19 Member Vaccination Incentive Program and \$65,600 from the OneCare Calendar Year 2024 Member Health Rewards Program to the Calendar Year 2026 OneCare Member Health Rewards Program.*

AYES: Jose Mayorga, Chair; Maura Byron; and Catherine Green
NOES: None
ABSENT: None
ABSTENTION: None
RECUSALS: None

INFORMATION ITEMS

6. Grant Management Activities and Updates

Kelly Bruno-Nelson, DSW, Executive Director, CalAIM, provided an update on grant management activities. She provided a presentation that reviewed several actively monitored grants.

Dr. Bruno-Nelson explained that per Board direction, CalOptima Health commissioned Chapman Consulting to assess its grant-management program against peer health plans and health philanthropies. She then introduced consultants Samantha Pellón and Gretchen Nye to present their analysis.

The consultants reported that CalOptima Health's framework was strong and broadly consistent with peers, noting that the grant portfolio's complexity is grounded in articulated funding priorities, having competitive grant making, lifecycle documentation, structured evaluation, and governance oversight. The consultant's presentation emphasized that CalOptima Health's conflict-of-interest policies and ethics requirements remain relevant even where grantmaking rules are flexible, and highlighted that CalOptima Health's grant program should maintain existing clear, consistent, and well-documented internal processes that align with evolving DHCS requirements, organizational priorities, and community needs while incorporating relevant leading practices from peer organizations. The presentation also noted review of 12 internal documents throughout the organization and observed that a lean team administers approximately 14-15 notice of funding opportunities (NOFOs) annually. The consultants concluded that CalOptima Health's foundation was strong and aligned with peers, while targeted process refinements could further improve consistency and reduce administrative burdens as the portfolio evolves.

Ms. Pellón further explained that following its analysis, Chapman Consulting identified five targeted opportunities to enhance clarity, consistency, and operational efficiency. She recommended formalizing enterprise-level funding priorities so staff can clearly determine which requests fall in or out of scope. Chapman Consulting also advised that CalOptima Health refine governance and portfolio management by better pacing NOFO releases and aligning reporting cycles with Board schedules to reduce administrative burden. Lastly, Ms. Pellón emphasized fully leveraging CalOptima Health's lifecycle templates and the new lifecycle software solution, noting that internal rigor exceeded what appears in external-facing materials such as NOFOs.

7. Quality Improvement Program Updates

- a. Quality Improvement Health Equity Transformation Program Quarterly Report
- b. Health Plan Accreditation Update

Ms. Lee provided an update on the quarter one activity of the Quality Improvement and Health Equity Committee (QIHEC). She noted that the QIHEC met monthly during the first quarter of 2026 and continued its oversight of quality performance, accreditation status, performance improvement projects, member experience metrics, access and availability, grievances and appeals, and coordination of care. She reviewed annual program documents, including the QIHEC Transformation Program, Population Health Management Strategy, cultural and linguistics services, and evaluations of prior Pay-for-Value programs.

Ms. Lee highlighted newly approved policies, such as those governing member requests for medical records. She also presented several significant quality findings. Ms. Lee further stated that CalOptima Health earned the National Committee for Quality Assurance (NCQA) Health Equity Accreditation in December 2025 and will remain accredited through December 2028. She noted that the plan remains on track for its next health plan survey.

Ms. Lee also reported that CalOptima Health established a monthly data sharing with Orange County Behavioral Health partners resulting in major accuracy improvements, including a 66% increase antipsychotic medication adherence, representing a 28-percentage-point gain largely driven by closing data gaps. She added updates on medication adherence support outreach involving 13,000 pharmacies and 3,400 members.

Ms. Lee also provided an overview of the various QIHEC sub-committee reports that included credentialing actions, probation and sanction monitoring, network-adequacy closures for OneCare, and ongoing Medi-Cal gap mitigation, noting that the Credentialing and Peer Review Committee reported three preventable provider conditions to DHCS. Ms. Lee further noted that the Member Experience Committee met in January 2026 and closed out the 2024 network adequacy validation virtual audit. For OneCare and Medi-Cal, the Member Experience sub-committee identified several gaps for access to care in several specialties and South Orange County. Lastly, Ms. Lee stated that the Utilization Management (UM) Committee revised four UM policies and 19 pharmacy policies. The Benefit Management Committee reviewed and reapproved 39 codes while the Pharmacy and Therapeutics Committee reviewed 11 new drugs where nine were added to the OneCare formulary with prior authorization.

Carmen Katsarov, Executive Director, Behavioral Health, responded to inquiries regarding antipsychotic medications and explained that long-acting injectable antipsychotics are typically administered in a clinical setting and processed through the Medi-Cal pharmacy benefit.

c. Quality Improvement Strategies

Kelli Glynn, Director, Quality Initiatives, presented an update on the quality improvement strategy, emphasizing a member-first, data driven, and provider-enabled approach. She described a multimodal outreach approach that tailored messages to members that reported barriers like customizing breast cancer screening reminders based on concerns about pain or fear and follow-up with messages that speak directly to those specific barriers. Ms. Glynn also highlighted improvements in data completeness and timeliness supported by Cozeva Payer One Strategy integrations and expanded on at-home testing programs. She also highlighted mobile mammography success and reported updates that included improvements on engaging “unengaged” members via optimized calling times and scheduling workflows.

d. Member Grievances and Appeals Report

Heather Sedillo, Director, Grievances, Appeals, and Resolution Services (GARS), provided an overview of the member grievances and appeals report for the first quarter of 2026.

8. Utilization Management & Clinical Operations Updates

Kelly Giardina, Executive Director, Clinical Operations and Dr. Robin Hatam, Medical Director, presented on UM timeliness, UM program performance, utilization outcomes, and sub-workgroup updates, health network clinical oversight, emergency department support, transitional care services, and new clinical initiatives.

9. Whole Child Model Age Out Transition-PCP Incentive Pilot

Ms. Giardina presented the three-year performance-based incentive pilot program designed to support members transitioning from pediatric to adult services at age 21. The pilot aims to reduce service disruption through warm handoffs, care coordination, and increased engagement from adult PCPs. Providers can earn incentive payments based on specific billing codes related to care coordination and transition activities. The initiative expects to improve member satisfaction while reducing unnecessary hospitalizations and emergency department use.

10. Quarterly Reports to the Quality Assurance Committee

- a. Quality Improvement Health Equity Committee Report
- b. Program of All-Inclusive Care for the Elderly Report

These items were received and filed.

COMMITTEE MEMBER COMMENTS

Committee members expressed gratitude for the positive updates shared during the meeting. Director Byron shared personal reflections on Chair Mayorga's mentorship and impact on her understanding of committee work. Chair Mayorga offered final remarks on his tenure, his commitment to community service, and his pride in the organization's legacy.

ADJOURNMENT

Hearing no further business, Chair Mayorga adjourned the meeting at 4:56 p.m.

Ruby Nunez
Executive Assistant

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 15, 2026 **Special Meeting of the CalOptima Health Board of Directors'** **Quality Assurance Committee**

Discussion Item

4. Approve the CalOptima Health Measurement Year 2027 Medi-Cal and OneCare Pay for Value Programs

Contacts

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069
Richard Lopez, M.D., Interim Chief Medical Officer, (657) 900-1483

Recommended Action

Recommend that the Board of Directors:

1. Approve CalOptima Health Measurement Year 2027 Medi-Cal Delegated Health Network Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
2. Approve CalOptima Health Measurement Year 2027 OneCare Delegated Health Network Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
3. Approve the Measurement Year 2027 CalOptima Health Community Network Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
4. Approve the Measurement Year 2027 Shared Risk Pool Quality Measures effective January 1, 2027, through December 31, 2027.

Background

CalOptima Health's Pay for Value Performance Program (P4V Program) recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health Networks (HNs), CalOptima Health Community Network (CHCN), and HN's primary care physicians (PCPs), are eligible to participate in the P4V Program.

The purpose of CalOptima Health's P4V Program is to:

1. Recognize and reward HNs and CHCN PCPs for demonstrating quality performance;
2. Drive improvement in quality outcomes and processes through monetary incentives and penalties;
3. Provide comparative performance information for members, providers, and the public on CalOptima Health's HN and CHCN PCP performance; and
4. Provide industry benchmarks and data-driven feedback to HNs and CHCN PCPs on their quality improvement efforts.

CalOptima Health staff have obtained feedback from HN and CHCN physician partners on recommendations to refine and improve the P4V Program to drive improvement and achieve quality goals. Based on this feedback, CalOptima Health has shifted from an annual, retrospective pay-for-performance model to a real-time, point-of-care incentive approach, enabling providers to earn incentives as care gaps are closed. This new model launched in July 2026 with OneCare CHCN, and is now expanding to Medi-Cal CHCN, positioning us for full implementation in the 2027 program year.

Discussion

Measurement Process

CalOptima Health staff calculates the quality rating score for each HN annually. For Measurement Year (MY) 2027, staff will use the Integrated Healthcare Association (IHA) methodology for both Medi-Cal and OneCare. This will enable CalOptima Health to use an industry standard methodology and improve efficiencies by using one standard quality rating methodology. The performance score is derived from the most recently available audited Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Centers for Medicare & Medicaid Services (CMS) Star measure data.

Medi-Cal Delegated HN P4V Program

Staff recommends implementing the MY 2027 Delegated HN Medi-Cal P4V Program with the following program components:

1. Maintain IHA pay for performance methodology to assess performance.
 - a. The methodology uses both attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.
 - b. The greater of either the attainment or improvement score will be used to calculate incentive payments.
 - c. A total quality score will be calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum. Measures are weighted 1.0 for clinical measures and 1.5 for member experience measures.
 - i. The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned. For example, a quality rating of 3.5 equates to 35% of the incentive allocation.
2. Utilize the MY 2027 Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures held to minimum performance level (MPL) for the HEDIS measurement set. Based on preliminary notice from DHCS, the MY 2027 Medi-Cal P4V Program will have a total of 20 quality measures. CalOptima Health's P4V Program will adopt the final MY 2027 MCAS MPL measure set upon availability by DHCS.
3. Continue to include CAHPS composites and overall ratings as member experience measures. Utilize both the child and adult CAHPS results, proportional to the age distribution of the

assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

4. Continue to use the National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles as benchmarks. For MY 2027, MY 2026 Medicaid percentiles will be used as benchmarks.
5. Maintain program funding methodology at 10% of professional capitation (risk adjusted base capitation only).
6. Implement corrective action for HNs that score below the 50th percentile, requiring the HN to submit an improvement plan for that measure to CalOptima Health.
7. Apply the DHCS quality withhold as follows:
 - a. DHCS will maintain its quality withhold and incentive program for managed care plans. For calendar year 2027, the quality withhold percent will remain 1.0% of capitation payments from each Medi-Cal managed care plan. DHCS may apply a higher withhold percentage in future Medi-Cal managed care plan contracts.
 - b. Based on the DHCS quality measures, CalOptima Health will be assessed for the amount of withhold payments that may be earned back. The unearned percentage will be applied in CalOptima Health's P4V calculation across all HNs. Staff recommends deducting the percent of unearned DHCS withhold from each HN's earned P4V Program payment.
8. Utilize unearned incentive dollars for CalOptima Health-led system-wide quality interventions such as member health reward programs, mobile or at-home health screenings, digital measure improvements, and other targeted initiatives. Upon availability of funding from unearned incentive dollars after use for CalOptima Health-led interventions, CalOptima Health will also issue quality grants to HNs that will be directed toward improving individual measures or groups of measures.

OneCare Delegated HN P4V Program

Staff recommend implementing the MY 2027 OneCare Delegated HN P4V Program with the following program components:

1. Adopt the IHA pay for performance methodology, as described in the Medi-Cal section above, to assess performance.
 - Performance will be calculated on a Star rating scale based on CMS Star ratings. Each measure can earn between 1 and 5 stars.
 - Measures are weighted 1.0 for process measures, 2.0 for member experience measures, and 3.0 for outcome measures.
2. Utilize select CMS Part C and D measures for the P4V measurement set. Selected measures are those that are directly aligned with HN responsibilities.

3. Utilize CMS Star cut-points as benchmarks. For MY 2027, the 2029 Star Rating cut points will be used.
4. Calculate the total quality score based on the sum of points earned for each measure on a scale of 1 to 5 stars.
5. Use the total quality score to determine the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned.
6. The percentage of OneCare incentive earned will be determined as follows:

OneCare P4V Performance	MY2027/ SY2029 Incentive Percent
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year; SY= Star rating display year

7. Maintain program funding at \$20 per member per month (PMPM).
8. Implement corrective action for HNs that score below 3-Stars, requiring the HN to submit an improvement plan for that measure to CalOptima Health.
9. Utilize unearned incentive dollars for CalOptima Health-led system-wide quality interventions such as member health reward programs, mobile or at-home health screenings, digital measure improvements, and other targeted initiatives.

MY 2027 CHCN Medi-Cal and OneCare PCP P4V Programs

CalOptima Health has implemented a real-time, physician P4V Program model for CHCN PCPs, transitioning away from the prior annual, retrospective structure. Staff recommends continuing this

real-time model into MY 2027, supporting improved quality performance and enhanced provider engagement through timely, actionable insights.

Staff recommends continued use of a software vendor to deliver the PCP P4V Program. The physician incentive software allows CalOptima Health contracted providers to view and close quality care gaps and earn corresponding P4V Program incentive dollars. The physician incentive software:

1. Provides a single view of health-promoting behaviors and corresponding incentive values through a simple user interface that engages PCPs and office staff.
2. Supports real-time updates to care gap closure status upon the physician/office staff taking action.
3. Ensures timely and transparent incentive payments to providers, providing payments throughout the year versus annually.

Providers will have visibility to their member panel with care gaps, actions that can earn incentives, and their progress made toward earning incentives as actions are taken and care gaps are closed. Incentives will range from \$5 to \$50 depending on the action taken and care gap closed.

The OneCare PCP P4V Program will utilize a two-tier incentive structure, with gap-closure payments of either \$25 or \$50 per qualifying action, reflective of the smaller OneCare member population and corresponding gap volume:

- Tier 1: \$25 per care gap closed for quality measures that have demonstrated stable performance and/or are lower in complexity.
- Tier 2: \$50 per care gap closed for quality measures where performance has plateaued, and/or are outcome-based.

The Medi-Cal PCP P4V Program will utilize a structured, three-tier incentive structure:

- Tier 1: \$5-\$25 per care gap closed for quality measures that require a single administrative touchpoint or are low in complexity.
- Tier 2: \$30-\$45 per care gap closed for quality measures that require clinical coordination (*e.g.*, multiple office visits required and/or are time-bound).
- Tier 3: \$50 per care gap closed for quality measures that require complex clinical management and/or are outcome-based.

The total incentive payout shall not exceed 10% of total capitation. Funding for this program will draw from unearned MY 2025 P4V Program funds.

MY 2027 Unearned Incentive Dollars

MY 2027 P4V funds that remain unused – due to HNs failing to earn the maximum incentive possible or due to forfeitures based on CalOptima Health’s failure to achieve the MPL – may be used for quality improvement initiatives. Upon availability of funding, HN grants will be available from unearned funds for Medi-Cal only.

HNs may apply for grants to utilize incentive dollars for quality improvement initiatives. Grants may be awarded for individual measures or groups of measures targeting similar member populations, for example, well-child visits and childhood immunizations. Total grant funds to an individual HN will not exceed the HN's maximum pool funding incentive for each MY, including deduction for DHCS quality withholds. Grants may not be used to fund administrative staffing nor for capital investments but may be used for staff for direct implementation of quality initiatives.

Staff will provide oversight of grants pursuant to CalOptima Health Policy AA.1400: Grants Management and will return to the Board of Directors (Board) to provide updates on the status of these grants at future meetings.

CalOptima Health will utilize a portion of the unearned MY 2027 CHCN HN P4V Program funds for the MY 2027 CHCN PCP P4V programs. CalOptima Health will also use unearned MY2027 Delegated and CHCN HN Program funds for CalOptima Health-led quality improvement initiatives such as member outreach and education, programs to close care gaps, and programs to close data gaps.

Unearned incentive funds will be used as described herein. Staff will finalize expenditures from the MY 2027 P4V programs by Quarter 4 of 2028 and report back to the Board.

Eligibility for Incentive Payments

Performance incentive payments to HNs are distributed upon final calculation and validation of each measurement rate. Performance incentive payments to CHCN PCPs are issued throughout the MY, with an additional payout after the MY closes to account for claims runout. To qualify for payments:

- A HN must be contracted with CalOptima Health during the entire measurement period (January 1, 2027, through December 31, 2027), the calculation period (January 1, 2027, through December 30, 2027), and at the time of disbursement of payment.
- Providers must be contracted as a PCP with CalOptima Health CHCN at the time of payment distribution and must have at least five (5) CalOptima Health members attributed at the TIN level for each line of business.
- HNs and PCPs must also be in good standing with CalOptima Health at the time of disbursement of payment. CalOptima Health considers a provider in good standing if they have a valid contract during service, measurement and payment periods, and are not subject to any sanctions, exclusions, or preclusions. This status is verified by the Audit and Oversight Department. HNs must distribute a minimum of 85% of their incentive payment to their contracted physicians.

Shared Risk Pool Quality Measurement

HNs under a shared risk arrangement are subject to meeting quality measurement requirements to receive payment from shared risk pool funds, as defined in CalOptima Policy FF.1010: Shared Risk Pool and Policy MA.3003: Medicare Shared Risk Pool.

For Medi-Cal, performance against the following selected P4V Program measures will determine eligibility for shared risk pool distribution:

1. Follow-Up after Emergency Department (ED) Visits for Mental Illness-30 Days.
2. Follow-Up After ED Visits for Substance Use-30 Days.
3. Prenatal and Postpartum Care: Postpartum Care (7-84 Days).
4. Follow-Up after ED Visits for Mental Illness-30 Days.

For OneCare, performance against the following selected P4V Program measures will determine eligibility for shared risk pool distribution:

1. Follow-Up After ED Visits for Substance Use-30 Days.
2. Plan All-Cause Readmissions (30-Days).
3. Transitions of Care (31-Days)
4. Follow-Up after ED Visit for People with Multiple High-Risk Chronic Conditions (7-Days)

To receive shared risk pool payments, HNs must achieve at least the 25th percentile across the four measures for Medi-Cal and four measures for OneCare, separately. Performance will be calculated by averaging the percentile achieved for each measure, with each measure equally weighted. Any HN that does not meet this requirement will forfeit their portion of shared risk pool funds for that product line. Staff currently forecast all HNs will meet the minimum performance percentile.

Fiscal Impact

Medi-Cal P4V Program

Staff estimates that the fiscal impact for the MY 2027 P4V Program will be no more than 10% of the professional capitation (base rate only) or approximately \$58 million. As a subset of this amount, staff estimates that approximately \$11 million will go toward CHCN PCPs. Staff will include estimated pool funding for the MY 2027 P4V Program initiatives and grant activities in the Fiscal Year (FY) 2027-28 Operating Budget.

OneCare P4V Program

Staff estimates that the fiscal impact for the MY 2027 OneCare P4V Program will be no more than \$20 PMPM or approximately \$4.7 million. As a subset of this amount, staff estimates that approximately \$1 million will go toward CHCN PCPs. Staff will include estimated pool funding for the MY 2027 P4V Program initiatives and grant activities in the FY 2027-28 Operating Budget.

Rationale for Recommendation

CalOptima Health strives to continuously improve the quality of care and outcomes for all members. CalOptima Health is committed to demonstrating breakthrough improvement in quality measures, achieving high performing managed care plan status, and achieving a 5-Star rating status. To achieve optimal quality performance and more fully engage the physician network, CalOptima Health will continue to shift from a retrospective P4V model to a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

CalOptima Health Board Action Agenda Referral
Recommend that the Board of Directors Approve the
CalOptima Health Measurement Year 2027 Medi-Cal and
OneCare Pay for Value Programs
Page 8

Attachments

1. CalOptima Health Measurement Year 2027 Pay for Value Programs
2. MY2027 Pay for Value Program Presentation

Attachment 1

CalOptima Health Measurement Year (MY) 2027 Pay for Value Programs

MY 2027 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V program also includes incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health primary care providers (PCPs) are eligible to participate in the Medi-Cal P4V program.

MY 2027 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2027 MCAS measure set.

MY 2027 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness - 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse - 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status - Combination 10	Breast Cancer Screening
Developmental Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents - Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS - Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS - Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months - Six or More Well-Child Visits	CAHPS - Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months - Six or More Well-Child Visits	CAHPS - Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS - Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS - Getting Care Quickly: Adult and Child
	CAHPS - Coordination of Care: Adult and Child

- Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.
2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
 - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
 - Scoring
 - Attainment Points

Attachment 1
CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

- Scale of 1-10 points
 - Points based on performance between 50th percentile and 95th percentile.
 - $1 + \left(\frac{(MY2027 \text{ Rate} - 50th \text{ Percentile})}{((95th \text{ Percentile} - 50th \text{ Percentile})/9)} \right)$
 - Improvement Points
 - Scale of 0-10 points
 - Points reflect performance in the prior year compared to the current year.
 - $\left(\frac{(MY2027 \text{ Rate} - MY2025 \text{ Rate})}{((95th \text{ Percentile} - MY2025 \text{ Rate})/10)} \right)$
3. Prior year (MY2026) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.
 4. Measure weighting
 - HEDIS measures weighted 1.0
 - CAHPS measures weighted 1.5
 5. A total quality score will be calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum.
 6. The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned. For example, a quality rating of 3.5 equates to 35% of the incentive allocation.
 7. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
 8. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.
 9. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.
 10. DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.

Attachment 1

CalOptima Health Measurement Year (MY) 2027 Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

MY 2027 OneCare P4V Program Components

Alignment with the CMS Star program and the following components- CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:

1. Utilize a subset of CMS Star measures

MY 2027 OneCare Pay for Value Program Measurement Set	
Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults - Medication Review
	Care for Older Adults - Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care - Eye Exam
	Comprehensive Diabetes Care - Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Depression Screening and Follow-Up for Adolescents and Adults
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
 - Attainment and Improvement score calculated for each measure. The better of the two scores is used.
 - Scoring
 - Attainment Points
 - Scale of 1-5 points
 - Points based on performance between 3-Star and 5-Star cut points.

Attachment 1

CalOptima Health Measurement Year (MY) 2027 Pay for Value Programs

- $1 + \left(\frac{(MY2027 \text{ Rate} - 3 \text{ Star cut point})}{((5 \text{ Star cut point} - 3 \text{ Star cut point})/4)} \right)$
- Improvement Points
 - Scale of 0-5 points
 - Points reflect performance in the prior year compared to the current year.
 - $\left(\frac{(MY2027 \text{ Rate} - MY2025 \text{ Rate})}{((5 \text{ Star cut point} - MY2025 \text{ Rate})/5)} \right)$
- 3. MY2027 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2028 in the 2029 Star Rating Technical Notes.
- 4. Measure weighting
 - HEDIS process measures weighted 1
 - CAHPS measures weighted 2
 - Outcome measures weighted 3
- 5. A total quality score will be calculated based on the sum of points earned for each measure on a scale of 1 to 5 stars.
- 6. The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned.

OneCare P4V Performance	MY2027 Incentive Percentage SY2029
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY = Star rating display year

- 7. Apply a program funding methodology of \$20 PMPM
- 8. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance
- 9. HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.

Attachment 1

CalOptima Health Measurement Year (MY) 2027 Pay for Value Programs

Primary Care Provider Pay for Value Program (P4V)

The CalOptima Health Community Network (CHCN) Primary Care Provider (PCP) P4V program incentives:

- Performance on select Healthcare Effectiveness Data and Information Set (HEDIS®) Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL), and
- Performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures.

Measures are developed from industry standards including HEDIS and Pharmacy Quality Alliance.

In 2026, CalOptima Health began the shift from an annual, retrospective pay-for-performance model to a real-time, point-of-care incentive approach, enabling CHCN providers to earn incentives as care gaps are closed. Under this new approach, CHCN providers can earn incentive payments throughout the measurement year as quality care gaps are closed, rather than waiting for year-end reconciliation. This transition is supported by the implementation of a physician incentive software platform, which delivers the PCP P4V Program and provides contracted CalOptima Health providers with a single, streamlined interface to identify, address, and close care gaps. Through this platform, providers can take real-time actions and immediately earn the corresponding P4V incentive dollars. The physician incentive software:

1. Provides a single view of health-promoting behaviors and corresponding incentive values through a simple user interface that engages PCPs and office staff.
2. Supports real-time updates to care gap closure status upon the physician/office staff taking action.
3. Ensures timely and transparent incentive payments to providers, providing payments throughout the year versus annually.

Providers will have visibility to their member panel with care gaps, actions that can earn incentives, and their progress made toward earning incentives as actions are taken and care gaps are closed. Incentives will range from \$5 to \$50 depending on the action taken and care gap closed. The OneCare Program will utilize a two-tier incentive structure, with gap-closure payments of either \$25 or \$50 per qualifying action.

- Tier 1: \$25 per care gap closed for quality measures that have demonstrated stable performance and/or are lower in complexity.
- Tier 2: \$50 per care gap closed for quality measures where performance has plateaued, and/or are outcome-based.

The Medi-Cal Program will utilize a structured three-tier model:

- Tier 1: \$5-\$25 per care gap closed for quality measures that require a single administrative touchpoint or are low in complexity.
- Tier 2: \$30-\$45 per care gap closed for quality measures that require clinical coordination (e.g. multiple office visits required and/or are time-bound).
- Tier 3: \$50 per care gap closed for quality measures that require complex clinical management and/or are outcome-based.

Providers must meet all program eligibility criteria:

Attachment 1

CalOptima Health Measurement Year (MY) 2027 Pay for Value Programs

1. Must be contracted as a primary care physician (PCP) with CalOptima Health CHCN at the time of payment distribution.
2. Must be in good standing with CalOptima Health at the time of payment distribution.
3. Must have at least 5 CalOptima Health members attributed at the TIN level for each line of business.

The total incentive payout shall not exceed 10 percent of total capitation for CHCN. Full program details are outlined in the Pay for Value Program Manual for CalOptima Health Community Network.

MY 2027 Medi-Cal P4V Program Components

Include select measures held to a DHCS MPL or quality withhold in the MY2027 MCAS measure set.

Measure	Tier	Amount Per Gap Closed
Depression Screening for Adolescents and Adults	Tier 1	\$10
Developmental Screening in the First Three Years of Life	Tier 1	\$10
Topical Fluoride in Children	Tier 1	\$10
Postpartum Depression Screening	Tier 1	\$10
Prenatal Depression Screening	Tier 1	\$10
Lead Screening in Children	Tier 1	\$15
Breast Cancer Screening	Tier 1	\$25
Cervical Cancer Screening	Tier 1	\$25
Colorectal Cancer Screening	Tier 1	\$25
Depression Follow-Up for Adolescents and Adults	Tier 2	\$30
Child and Adolescent Well-Care Visits	Tier 2	\$30
Prenatal and Postpartum Care: Postpartum Care	Tier 2	\$30
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Tier 2	\$30
Postpartum Depression Follow Up	Tier 2	\$30
Prenatal Depression Follow Up on Positive Screen	Tier 2	\$30
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Two or More Well-Child Visits	Tier 2	\$40
Childhood Immunization Status- Combination 10	Tier 2	\$45
Immunizations for Adolescents- Combination 2	Tier 2	\$45
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	Tier 2	\$45
Follow-up After ED Visit for Mental Illness- 30 days*	Tier 3	\$50
Follow-Up After ED Visit for Substance Abuse- 30 days*	Tier 3	\$50
Controlling High Blood Pressure**	Tier 3	\$50
Glycemic Status Assessment for Patients with Diabetes ($\leq 9\%$)**	Tier 3	\$50

* Because members may qualify for a measure multiple times, incentives will only be paid for up to three (3) denominator eligible events per member. For example, if a member meets the measure criteria ten (10) times, incentives can be earned for no more than three (3).

Attachment 1
CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

** Incentive determination will be based on the member's last qualifying value or test completed within the measurement year.

Attachment 1
CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

MY 2027 OneCare P4V Program Components

Alignment with the CMS Star program through the use of Part C and Part D measures, along with corresponding measure weights and Star cut-point benchmarks, by utilizing a defined subset of CMS Star measures.

Measure	Amount Per Gap Closed
Care for Older Adults – Medication Review	\$25
Care for Older Adults – Functional Status Assessment	\$25
Osteoporosis Management in Women who had a Fracture	\$25
Diabetes Care – Eye Exam	\$25
Kidney Health Evaluation for Patients with Diabetes	\$25
Statin Therapy for Patients with Cardiovascular Disease	\$25
Transitions of Care: Medication Reconciliation	\$25
Transitions of Care: Patient Engagement After Inpatient Discharge	\$25
Depression Screening and Follow-Up for Adolescents and Adults	\$25
Statin Use in Persons with Diabetes (SUPD)	\$25
Breast Cancer Screening	\$50
Colorectal Cancer Screening	\$50
Diabetes Care – Blood Sugar Controlled**	\$50
Controlling Blood Pressure**	\$50
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions*	\$50

* Because members may qualify for a measure multiple times, incentives will only be paid for up to three (3) denominator eligible events per member. For example, if a member meets the measure criteria ten (10) times, incentives can be earned for no more than three (3).

** Incentive determination will be based on the member's last qualifying value or test completed within the measurement year.

Attachment 1
CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

Shared Risk Pool Quality Measurement

Medi-Cal MY2027 Quality Measures

1. Follow-Up after ED Visits for Mental Illness-30 Days
2. Follow-Up After ED Visits for Substance Use- 30 days
3. Prenatal and Postpartum Care: Postpartum Care (7-84 days)

Medicare MY2027 Quality Measures

1. Follow-Up After ED Visits for Substance Use- 30 Days
2. Plan All-Cause Readmissions (30-Days)
3. Transitions of Care (31-Days)
4. Follow-Up after ED Visit for People with Multiple High-Risk Chronic Conditions (7-Days)

Performance Calculation

For each measure, the rate achieved will be compared to the prior year (MY2026) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles. An averaged performance will be calculated by averaging the percentiles of achievement for the three measures. A minimum of the 25th percentile in average is required to receive payment from the shared risk pool. Any HN that does not meet this requirement will forfeit their portion of shared risk pool funds.



**CalOptima
Health**

Measurement Year (MY) 2027 Pay for Value Program

**Special Quality Assurance Committee
Meeting**

October 15, 2026

**Linda Lee, Executive Director, Quality
Improvement**

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Background

- CalOptima Health has implemented the Pay for Value (P4V) Program to reward high-performing Health Networks.
- The MY2026 P4V program was approved in November 2025.
- The intent for MY2027 is to carry forward the same core program components, while introducing targeted enhancements for Primary Care Providers (PCPs).



MY2027 Health Network Pay for Value Program Components

MY2027 P4V Program Elements

○ Measure Sets

- Medi-Cal: Align with Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and Quality Withhold measures
 - Utilize HEDIS and DHCS clinical measures
 - Utilize both Child and Adult CAHPS rates
- OneCare: Align with Centers for Medicare & Medicaid (CMS) Star measures most impactable by Health Networks (HN)s
 - Utilize Part C HEDIS and CAHPS measures
 - Utilize Part D medication management measures

MY2027 P4V Program Elements

○ Measure Weights

- Align with industry measure weights, where applicable
- Medi-Cal
 - Clinical measures = 1.0
 - Member experience measures = 1.5
- OneCare
 - Process measures = 1.0
 - Member experience measures = 2.0
 - Outcome measures = 3.0

○ Data Collection Methodology

- To promote adoption of electronic clinical data sets, utilize administrative data

Performance Methodology and Benchmarks

- Adopt Integrated Healthcare Association (IHA) scoring methodology
 1. Performance points are calculated by comparing HN score to benchmarks, starting at the 50th percentile for Medi-Cal and 3-Stars for OneCare
 2. Performance points are also calculated by comparing a HN's prior year score to current score
- Use option 1 or 2, selecting option with higher number of points
- Medi-Cal
 - Based on NCQA National Medicaid Percentiles
- OneCare
 - Based on CMS Star cut points

Medi-Cal P4V Incentive Percentages

- A total quality score is calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum.
- The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned.
 - For example, a quality rating of 3.5 equates to 35% of the incentive allocation

OneCare P4V Incentive Percentages

- A total quality score is calculated based on the sum of points earned for each measure on a scale of 1 to 5 stars

OneCare P4V Performance	MY2027 Incentive Percentage Earned Star Year 2029
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Health Network Corrective Action

- Corrective action: HN scoring below the 50th percentile on Medi-Cal or below 3.0 Stars on Medicare must submit a corrective action plan

Additional Health Network Penalties

- CalOptima Health will pass down any impact of the DHCS quality withhold program
 - For MY2027, the withhold is 1.0% of capitation
 - Any unearned withhold will be deducted from each HN's PV4 program payment

MY2027 Incentive Pool

- Medi-Cal:
 - Ten percent of professional capitation (base rate only)
 - Estimated at \$50 million
- OneCare:
 - \$20 pmpm
 - Estimated at \$4.7 million

Unearned Incentive Dollars

- CalOptima Health will implement system-wide quality interventions (e.g., member reward programs, mobile or at-home health screenings, and other targeted initiatives).
- When funding is available, CalOptima Health will issue quality grants to HNs using unearned dollars.
- Grants will be directed toward improving individual measures or groups of measures.
- Funds may support a range of quality improvement activities, including staffing dedicated to quality initiatives.
- HNs submit a plan, subject to semi-annual monitoring
 - Must meet implementation requirements to continue to access improvement funds.



MY2027 Primary Care Provider P4V Program Components

Primary Care Provider P4V

- CalOptima Health will implement a P4V program for primary care providers (PCPs) contracted directly with the CalOptima Health Community Network (CHCN).
- In 2026, CalOptima Health shifted from an annual, retrospective pay-for-performance model to a real-time, point-of-care incentive approach, enabling providers to earn incentives as care gaps are closed.
- This new model launched in July 2026 with OneCare CHCN, and is now expanding to Medi-Cal CHCN, positioning us for full implementation in the 2027 program year.

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.



Primary Care Provider P4V (cont.)

- Features of the PCP P4V program include:
 - Ongoing, transparent payment schedule:
 - Instead of receiving incentive payments once a year, providers will now receive monthly payments throughout the year as care gaps are closed.
 - New software platform:
 - CalOptima Health will utilize a software platform called Cozeva to deliver the P4V program.
 - Through Cozeva, providers will have a single interface to view care gaps, take actions, and earn incentives.
 - Cozeva will support real-time updates and transparent incentive payments throughout the measurement year.

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.



Primary Care Provider P4V (cont.)

- Providers must meet all program eligibility criteria:
 - Must be contracted as a primary care physician (PCP) with CalOptima Health CHCN at the time of payment distribution.
 - Must be in good standing with CalOptima Health at the time of payment distribution.
 - Must have at least 5 CalOptima Health members attributed at the TIN level for each line of business.

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.



Primary Care Provider P4V: Medi-Cal

- Incentives range from \$5 to \$50 depending on the action taken and care gap closed.
- Tier 1 (\$5-\$25):
 - Single administrative touchpoint or low complexity
- Tier 2 (\$30-\$45):
 - Clinical coordination (e.g. multiple office visits required and/or time-bound)
- Tier 3 (\$50):
 - Complex clinical management/outcomes-based

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

Primary Care Provider P4V: OneCare

- Incentives range from \$25 to \$50 depending on the action taken and care gap closed.
- Tier 1: \$25 per care gap closed for quality measures that have demonstrated stable performance and/or are lower in complexity.
- Tier 2: \$50 per care gap closed for quality measures where performance has plateaued, and/or are outcome-based.

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

MY2027 CHCN* PCP P4V Program: Medi-Cal Measures (Tier 1)

Measure	Incentive Amount Per Gap Closed
Topical Fluoride in Children	\$10
Depression Screening for Adolescents and Adults	\$10
Development Screening in the First Three Years of Life	\$10
Postpartum Depression Screening	\$10
Prenatal Depression Screening	\$10
Lead Screening in Children	\$15
Breast Cancer Screening	\$25
Cervical Cancer Screening	\$25
Colorectal Cancer Screening	\$25

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

MY2027 CHCN* PCP P4V Program:

Medi-Cal Measures (Tier 2)

Measure	Incentive Amount Per Gap Closed
Prenatal and Postpartum Care: Postpartum Care	\$30
Prenatal and Postpartum Care: Timeliness of Prenatal Care	\$30
Child and Adolescent Well-Care Visits	\$30
Depression Follow-Up for Adolescents and Adults	\$30
Postpartum Depression Follow Up	\$30
Prenatal Depression Follow Up on Positive Screen	\$30
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Two or More Well-Child Visits	\$40
Childhood Immunization Status- Combination 10	\$45
Immunizations for Adolescents- Combination 2	\$45
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	\$45

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.



MY2027 CHCN* PCP P4V Program: Medi-Cal Measures (Tier 3)

Measure	Incentive Amount Per Gap Closed
Follow-up After ED Visit for Mental Illness- 30 days**	\$50
Follow-Up After ED Visit for Substance Abuse- 30 days**	\$50
Controlling High Blood Pressure***	\$50
Glycemic Status Assessment for Patients with Diabetes ($\leq 9\%$)***	\$50

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

**Because members may qualify for a measure multiple times, incentives will only be paid for up to three denominator-eligible events per member. For example, if a member meets the measure criteria ten times, incentives can be earned for no more than three.

***Incentive determinations will be based on the member's last qualifying value or test completed within the measurement year.



MY2027 CHCN* PCP P4V Program: OneCare Measures

Measure	Incentive Amount Per Gap Closed
Breast Cancer Screening	\$50
Colorectal Cancer Screening	\$50
Care for Older Adults – Medication Review	\$25
Care for Older Adults – Functional Status Assessment	\$25
Osteoporosis Management in Women who had a Fracture	\$25
Diabetes Care – Eye Exam	\$25
Diabetes Care – Blood Sugar Controlled**	\$50
Kidney Health Evaluation for Patients with Diabetes	\$25
Controlling Blood Pressure**	\$50

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed the CHCN incentive allocation.

**Incentive determinations will be based on the member's last qualifying value or test completed within the measurement year.



MY2027 CHCN* PCP P4V Program: OneCare Measures (cont.)

Measure	Incentive Amount Per Gap Closed
Transitions of Care: Medication Reconciliation	\$25
Transitions of Care: Patient Engagement After Inpatient Discharge	\$25
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	\$50
Statin Use in Persons with Diabetes	\$25
Depression Screening and Follow-Up for Adolescents and Adults	\$25

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed the CHCN incentive allocation.

**Because members may qualify for a measure multiple times, incentives will only be paid for up to three denominator-eligible events per member. For example, if a member meets the measure criteria ten times, incentives can be earned for no more than three.





Shared Risk Pool Quality Measurement

Medi-Cal Shared Risk Pool Quality

- HNs under shared risk arrangement must meet quality measurement requirements to receive shared risk pool payments
- An average performance of the 25th percentile across measures is required to earn shared risk pool payments
- For MY2027 the measures are:
 - Follow-Up after ED Visits for Mental Illness-30 Days
 - Follow-Up After ED Visits for Substance Use- 30 days
 - Prenatal and Postpartum Care: Postpartum Care (7-84 days)

Medicare Shared Risk Pool Quality

- HNs under shared risk arrangement must meet quality measurement requirements to receive shared risk pool payments
- An average performance of the 25th percentile across measures is required to earn shared risk pool payments
- For MY2027 the measures are:
 - Follow-Up After ED Visits for Substance Use- 30 Days
 - Plan All-Cause Readmissions (30-Days)
 - Transitions of Care (31-Days)
 - Follow-Up after ED Visit for People with Multiple High-Risk Chronic Conditions (7-Days)



APPENDIX

MY2027 Medi-Cal Health Network P4V Measurement Set

Measure	Measure
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Developmental Screening in the First Three Years of Life	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening

MY2027 Medi-Cal Health Network P4V Measurement Set

Measure	Measure
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

MY2027 OneCare Health Network P4V Measurement Set

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults - Medication Review
	Care for Older Adults - Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Depression Screening and Follow-Up for Adolescents and Adults

MY2027 OneCare Health Network P4V Measurement Set

Measure Category	Measure
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines



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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 15, 2026 Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Discussion Item

5. Approve the Measurement Year 2027 CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168
Richard Lopez, M.D., Interim Chief Medical Officer, (657) 900-1483

Recommended Action

Recommend that the Board of Directors approve the Measurement Year 2027 Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program, effective January 1, 2027, through December 31, 2027.

Background

During the November 7, 2024, CalOptima Health Board of Directors (Board) meeting, the Board approved modifications to the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value (MH Provider P4V) Program measures to better align with providers' administrative capabilities. The MH Provider P4V Program measures previously approved and listed in the table below continue to align with established standards, including selected Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures, Department of Managed Health Care (DMHC) timely access requirements, and clinical industry best practices. The MH Provider P4V Program is a proprietary CalOptima Health program.

	Category	Program Measures	Measure Value %
1	Quality Process	Timely Follow-up After BH/SUD/ED* visit	2.0%
2	Quality Process	Timely Follow-up After Initial Visits	2.0%
3	Quality Process	Effective Ongoing Care	1.0%
4	Capacity/Growth	Capacity/Panel Growth	2.0%
5	Care Effectiveness	Quality Monitoring of Essential Labs and Diagnostics	1.0%
6	Care Effectiveness	Clinical Measurement of Care	1.0%
7	Care Experience	Care Experience (Member Satisfaction)	1.0%
		Total	10%

*Behavioral Health (BH)/Substance Use Disorder (SUD)/Emergency Department (ED)

Discussion

After completing a comprehensive review of the first two measurement periods (January 1–June 30, 2025, and July 1–December 31, 2025), CalOptima Health staff identified several key adjustments to

improve program alignment, reduce provider burden, and enhance measurement relevance. As a result, staff recommends the following modifications for implementation in the measure year (MY) 2027 MH P4V Program:

- **Discontinue Quality Monitoring of Essential Labs and Diagnostics (Measure 5):** Collecting lab values in the CalOptima Health Provider Portal did not add value for HEDIS reporting because it does not capture the documentation required for audit and validation and creates a burden to providers to enter manually.
- **Modify Clinical Measurement of Care (Measure 6):** Add and require the Patient Health Questionnaire-9 (PHQ-9) assessment for ages 12 years old and above, to support the HEDIS measure for Depression Screening and Follow-Up (DSF).
- **Discontinue Care Experience (Member Satisfaction) (Measure 7):** The quarterly text-based CalOptima Health Member Experience survey resulted in extremely low response rates, leaving insufficient data to support incentive eligibility.

Measurement and Payout Periods

The earned incentive of up to 10% premium on adjudicated claims remains unchanged. CalOptima Health calculates provider rating scores semiannually, allowing providers to track performance through scorecards. Incentive payments are issued after final calculation and validation. To qualify, mental health providers must maintain an active contract with CalOptima Health throughout the measurement and payout periods and remain in good standing as determined by the Audit and Oversight Department. Based on performance, providers may earn up to a 10% premium on adjudicated claims in the prospective payment period. The tables below outline the recommended measures, measure values, measurement periods, and payout periods for the MY 2027 MH P4V Program.

	Category	Program Measures	Measure Value %
1	Quality Process	Timely Follow-up After BH/SUD ED visit	2.5%
2	Quality Process	Timely Follow-up After Initial Visits	2.5%
3	Quality Process	Effective Ongoing Care	1.0%
4	Capacity/Growth	Capacity/Panel Growth	2.0%
5	Care Effectiveness	Clinical Measurement of Care	2.0%
		Total	10%

MY 2027 Measurement Period	MY 2027 Payout Period
January 1 - June 30, 2027	January 1 - June 30, 2028
July 1 - December 31, 2027	July 1 - December 31, 2028

Fiscal Impact

Staff estimates that the annual fiscal impact for each payout period for the MY 2027 MH P4V Program will be no more than 10% of the contractually paid claim amounts or approximately \$6.1 million. The estimated payments for the proposed payout periods will be included in future operating budgets.

Rationale for Recommendation

The MY 2027 MH P4V Program will continue to improve the quality of care for CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action dated May 2, 2024: Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program
2. Previous Board Action dated November 7, 2024: Approve Modifications to the CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program
3. Behavioral Health Integration Mental Health Providers Pay for Value Programs Presentation

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2024

Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Action

1. Approve the CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program with measurement periods starting January 1, 2025, through December 31, 2026.

Background

CalOptima Health's existing Medi-Cal Pay-for-Value (P4V) Program has aligned and incentivized performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) measures included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. The OneCare P4V Program utilizes Centers for Medicare & Medicaid Services (CMS) Star HEDIS and CAHPS measures and focuses on the most significant improvement opportunity.

Discussion

The Behavioral Health Integration leadership recommends implementing the Mental Health (non-Applied Behavior Analysis (ABA)) Provider P4V Program for mental health providers contracted directly with CalOptima Health. CalOptima Health's members have established trusted relationships with their physicians and mental health providers, which can help drive quality measures and member care coordination. The program will use industry standard measures aligned with federal and state requirements and guidance (*e.g.*, DHCS MCAS, CMS Star measurement sets) and applicable Department of Managed Health Care standards. The following provides more detail on the components of the Mental Health (non-ABA) Provider P4V Program.

Quality Measures

The mental health (non-ABA) providers will be measured according to the following 10 quality measures. Each provider's score that meets or exceeds the target will earn 100% of the incentive allocation for that measure.

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
1	Follow-Up After ED Visit for Mental Illness—30 days	FUM	NCQA	2.0
2	Follow-Up After ED Visit for Substance Use—30 days	FUA	NCQA	2.0
3	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA	.75

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
4	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	.75
5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	SSD	NCQA	.75
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-E C&M	NCQA	.75
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-E Init	NCQA	.75
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM-E	NCQA	.75
9	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	NCQA	.75
10	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	NCQA	.75
Total				10

Program Methodology

The quality measures will be compared to the DHCS Minimum Performance Levels (MPL) at the 50th percentile and Medicare measures will be compared to the National Committee for Quality Assurance (NCQA) Medicare National Percentile Benchmarks. The performance compared to benchmarks will earn incentives based on to following:

Performance Benchmark	Percent of Incentive Earned per Measure
50 th percentile	50%
75th percentile	75%
90th percentile	100%

Program Measurement Period and Payout

The incentive budget is allocated based on the percentage of paid claims. Providers will be able to earn up to 10% of the paid claims during each measurement period based on their performance against the quality measures:

	Measurement Period	Incentive Payment Timeframe*
Baseline	January – December 2024	NA
Year 1	January – December 2025	Quarter 4 2026
Year 2	January – December 2026	Quarter 4 2027

*Incentive Payment Timeframe will be affected by HEDIS reporting timeframes and claims lag

Measurement Process and Incentive Payments

To qualify for incentive payments, mental health (non-ABA) providers must be contracted with CalOptima Health during the entire measurement period, be currently contracted, and in good standing with CalOptima Health, as determined by the Audit and Oversight Department. CalOptima Health staff

will calculate the rating score for the mental health (non-ABA) providers. The provider's performance score will be derived from the most recently audited plan-level HEDIS results. Providers can monitor their performance and progress through scorecards distributed by CalOptima Health. The distribution of the performance incentive payment will be based on each measure's rate final calculation and validation.

Fiscal Impact

Staff estimates that the annual fiscal impact for each measurement year for the Mental Health (non-ABA) Provider P4V Program will be no more than 10% of the paid claims during each measurement period or approximately \$3.1 million.

Management will include 100% of pool funding for the measurement year (MY) 2025 Mental Health (non-ABA) Provider P4V Program initiatives in the Fiscal Year 2024-25 Operating Budget. The estimated payout for MY 2026 will be included in future operating budgets.

Rationale for Recommendation

The Mental Health (non-ABA) Provider P4V Program will improve the quality of care for our CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn
Authorized Signature

04/26/2024
Date

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2024

Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve Modifications to the CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168

Recommended Actions

Approve the modifications to the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program measures.

Background

On May 2, 2024, the Behavioral Health Integration leadership recommended implementing the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program (Program) for mental health providers contracted directly with CalOptima Health. The Board of Directors approved the Program for measurement periods starting January 1, 2025, through December 31, 2026, for mental health providers contracted directly with CalOptima Health. The initial intent of the Program was to use industry standards aligned with federal and state requirements and guidance (e.g., Department of Health Care Services (DHCS), Managed Care Accountability Set (MCAS), Centers for Medicare and Medicaid Services (CMS) Star measurement sets).

Discussion

Initially, the mental health (non-ABA) providers were to be measured according to the 10 quality measures listed below:

#	Quality Measures
1	Follow-Up After ED Visit for Mental Illness—30 days
2	Follow-Up After ED Visit for Substance Use—30 days
3	Depression Screening and Follow-Up for Adolescents and Adults
4	Depression Remission or Response for Adolescents and Adults
5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics
9	Antidepressant Medication Management: Acute Phase Treatment
10	Antidepressant Medication Management: Continuation Phase Treatment

During an internal reevaluation of the Program before the intended go-live of January 2025, CalOptima Health had to revise the Program measures to align to the unique providers' current capabilities related to providing supplemental data submissions to show evidence of how the measures have been met. The updated measures listed in the table below will continue to align with the combination of standards,

including some HEDIS quality measures, Department of Managed Health Care (DMHC) timely access standards, and clinical industry best practices. Each provider's score that meets or exceeds the target will earn 100% of the incentive allocation for that measure. This Program is a CalOptima Health proprietary designed program.

	Category	Program Measures
1	Quality Process	Timely Follow-up After BH/SUD ED visit
2	Quality Process	Follow-up After Initial Visits
3	Quality Process	Effective Ongoing Care
4	Capacity/Growth	Capacity/Panel Growth
5	Care Effectiveness	Quality Monitoring of Essential Labs and Diagnostics
6	Care Effectiveness	Clinical Measurement of Care
7	Care Experience	Care Experience (Member satisfaction)

Substance Use Disorder (SUD) / Emergency Department (ED)

Program Methodology

The data collection will be captured by various methods such as claims/encounter data, provider attestation forms, and digital surveys. The measurement review will be performed semi-annually.

The providers will be able to earn up to a 10% additional payment on claims during the payout period by achieving any or all the Program elements in the measurement period. The payout to providers will follow prospective payment methodology.

Measurement Period	Payout Period
Jan – Jun 2025	Jan – Jun 2026
July – Dec 2025	Jul – Dec 2026
Jan – Jun 2026	Jan – Jun 2027
July – Dec 2026	Jul – Dec 2027

To be eligible for this Program, the behavioral health providers must maintain a contract with CalOptima Health throughout the measurement period, still be contracted with CalOptima health, and be in good standing, as determined by the Audit and Oversight Department. CalOptima Health will have sole discretion to modify measurements and targets to drive maximum quality performance and will provide regular reports to the CalOptima Health Quality Assurance Committee.

Fiscal Impact

Staff estimates that the annual fiscal impact for each payout period for the Program will be no more than 10% of the paid claims or approximately \$4.2 million on an annual basis. The estimated payments for the proposed payout periods will be included beginning with the Fiscal Year 2025-26 and will also be incorporated in future operating budgets.

Rationale for Recommendation

The Program will improve the quality of care for CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Previous Board Action dated May 2, 2024, Approve CalOptima Health Mental Health \(non-Applied Behavior Analysis\) Provider Pay-for-Value Program](#)

/s/ Michael Hunn
Authorized Signature

11/01/2024
Date

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2024

Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Action

1. Approve the CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program with measurement periods starting January 1, 2025, through December 31, 2026.

Background

CalOptima Health's existing Medi-Cal Pay-for-Value (P4V) Program has aligned and incentivized performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) measures included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. The OneCare P4V Program utilizes Centers for Medicare & Medicaid Services (CMS) Star HEDIS and CAHPS measures and focuses on the most significant improvement opportunity.

Discussion

The Behavioral Health Integration leadership recommends implementing the Mental Health (non-Applied Behavior Analysis (ABA)) Provider P4V Program for mental health providers contracted directly with CalOptima Health. CalOptima Health's members have established trusted relationships with their physicians and mental health providers, which can help drive quality measures and member care coordination. The program will use industry standard measures aligned with federal and state requirements and guidance (e.g., DHCS MCAS, CMS Star measurement sets) and applicable Department of Managed Health Care standards. The following provides more detail on the components of the Mental Health (non-ABA) Provider P4V Program.

Quality Measures

The mental health (non-ABA) providers will be measured according to the following 10 quality measures. Each provider's score that meets or exceeds the target will earn 100% of the incentive allocation for that measure.

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
1	Follow-Up After ED Visit for Mental Illness—30 days	FUM	NCQA	2.0
2	Follow-Up After ED Visit for Substance Use—30 days	FUA	NCQA	2.0
3	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA	.75

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
4	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	.75
5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	SSD	NCQA	.75
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-E C&M	NCQA	.75
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-E Init	NCQA	.75
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM-E	NCQA	.75
9	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	NCQA	.75
10	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	NCQA	.75
Total				10

Program Methodology

The quality measures will be compared to the DHCS Minimum Performance Levels (MPL) at the 50th percentile and Medicare measures will be compared to the National Committee for Quality Assurance (NCQA) Medicare National Percentile Benchmarks. The performance compared to benchmarks will earn incentives based on to following:

Performance Benchmark	Percent of Incentive Earned per Measure
50 th percentile	50%
75th percentile	75%
90th percentile	100%

Program Measurement Period and Payout

The incentive budget is allocated based on the percentage of paid claims. Providers will be able to earn up to 10% of the paid claims during each measurement period based on their performance against the quality measures:

	Measurement Period	Incentive Payment Timeframe*
Baseline	January – December 2024	NA
Year 1	January – December 2025	Quarter 4 2026
Year 2	January – December 2026	Quarter 4 2027

*Incentive Payment Timeframe will be affected by HEDIS reporting timeframes and claims lag

Measurement Process and Incentive Payments

To qualify for incentive payments, mental health (non-ABA) providers must be contracted with CalOptima Health during the entire measurement period, be currently contracted, and in good standing with CalOptima Health, as determined by the Audit and Oversight Department. CalOptima Health staff

will calculate the rating score for the mental health (non-ABA) providers. The provider's performance score will be derived from the most recently audited plan-level HEDIS results. Providers can monitor their performance and progress through scorecards distributed by CalOptima Health. The distribution of the performance incentive payment will be based on each measure's rate final calculation and validation.

Fiscal Impact

Staff estimates that the annual fiscal impact for each measurement year for the Mental Health (non-ABA) Provider P4V Program will be no more than 10% of the paid claims during each measurement period or approximately \$3.1 million.

Management will include 100% of pool funding for the measurement year (MY) 2025 Mental Health (non-ABA) Provider P4V Program initiatives in the Fiscal Year 2024-25 Operating Budget. The estimated payout for MY 2026 will be included in future operating budgets.

Rationale for Recommendation

The Mental Health (non-ABA) Provider P4V Program will improve the quality of care for our CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn
Authorized Signature

04/26/2024
Date



CalOptima Health

Behavioral Health Integration(BHI) Mental Health Providers Pay-for- Value (P4V) Programs

**Quality Assurance Committee
October 15, 2026**

**Carmen Katsarov, Executive Director,
Behavioral Health Integration**

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Background – MH BH P4V

- Board approved May 18, 2024 and November 7, 2024
- Program started January 1, 2025
- Providers can qualify for up to a 10% incentive applied to adjudicated paid claims during the payout period
- Program Framework
 - Measurement Period: **Every 6 months**
 - Data Source: Claims and encounter submissions, lab attestations, and mental health assessments
 - Review Frequency: Semi-annual performance review

Measurement Period	Review Period	Payout Period
Jan 1 – Jun 30, 2025	Jul 1 - Dec 31, 2025	Jan 1 – Jun 30, 2026
Jul 1 – Dec 31, 2025	Jan 1 – Jun 30, 2026	Jul 1 – Dec 31, 2026
Jan 1 – Jun 30, 2026	Jul 1 – Dec 31, 2026	Jan 1– Jun 30, 2027
Jul 1 – Dec 31, 2026	Jan 1 – June 30, 2027	Jul 1 – Dec 31, 2027

Measurement and Prospective Payout Periods

2026												2027											
Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec
Measurement Period #3 Jan-Jun 2026 Services																							
						Payout Period #2 Jul - Dec 2025 Services																	
						Measurement Period #4 Jul - Dec 2026																	
												Payout Period #3 Jan-Jun 2026 Services											
																		Payout Period #4 Jul-Dec 2026					
												Measurement Period #5 Jan - June 2027 (pending QAC approval)											
																		Measurement Period #6 Jul - Dec 2027 (pending QAC approval)					

MH P4V Provider Performance

	Metric	MP: 1/1 – 6/30 2025	MP: 7/1 – 12/31 2025	MP: 1/1 - 6/30 2026*
1	Timely Follow-up after BH/SUD ED visit	33%	20%	14%
2	Timely Follow-up after initial visits	22%	10%	15%
3	Effective ongoing care	5%	2%	2%
4	Capacity / Panel Growth	77%	67%	57%
5	Quality monitoring of essential labs and diagnostics	N/A	0%	0%
6	Clinical Measurement of Care	N/A	0%	0%
7	Care Experience (Member Satisfaction) survey	0%	Discontinue	Discontinue

*Preliminary results as of 8/27/26

MH P4V: Program Modifications 2027 - 2028

- Modifications are based on internal reviews and discussions with the HEDIS team:
 - Discontinue Quality Monitoring of Essential Labs and Diagnostics (Metric 5): The manually entered lab values did not contain the supporting documentation necessary for HEDIS audit and validation thus it could not reliably contribute to HEDIS reporting.
 - Modify Clinical Measurement of Care (Metric 6): Add and require the Patient Health Questionnaire-9 (PHQ-9) assessment to support the HEDIS measure Depression Screening and Follow-Up (DSF).*
 - Discontinue Care Experience (Member Satisfaction) (Metric 7): The quarterly text-based CalOptima Health Member Experience survey resulted in extremely low response rates, leaving insufficient data to support incentive eligibility.

*Effective by July 1, 2027, depending on the availability of IT resources

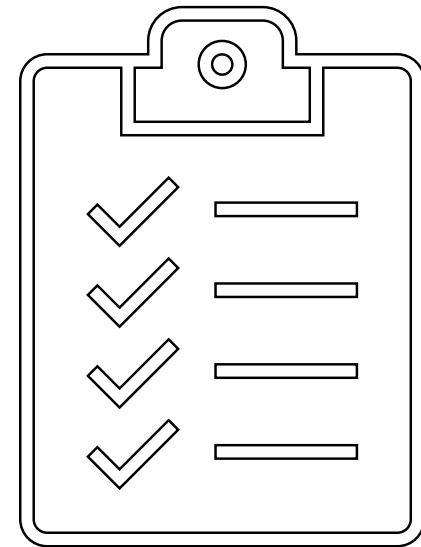
MH P4V Program: 2027 -2028

	Category	Program Metrics	Metric Value %
1	Quality Process	Timely Follow-up After BH/SUD ED visit	2.5%
2	Quality Process	Timely Follow-up After Initial Visits	2.5%
3	Quality Process	Effective Ongoing Care	1.0%
4	Capacity/Growth	Capacity/Panel Growth	2.0%
5	Care Effectiveness	Clinical Measurement of Care	2.0%
		Total	10%

Measurement Period	Payout Period
January 1 - June 30, 2027	January 1 – June 30, 2028
July 1 – December 31, 2027	July 1 – December 31, 2028

MH P4V Program Next Steps

- QAC approve the program for measurement periods between January 1, 2027, and December 31, 2027
- Present as a Consent Item for the November 5, 2026, Board of Directors Meeting to continue the program
- Provide annual program updates to QAC for review and approval to maintain program continuation.





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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 15, 2026 **Special Meeting of the CalOptima Health Board of Directors'** **Quality Assurance Committee**

Discussion Item

6. Approve the CalOptima Health Calendar Year 2027 Member Health Rewards Program

Contact

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

Recommend that the Board of Directors approve the CalOptima Health Calendar Year 2027 Member Health Rewards Program for Medi-Cal and OneCare, effective January 1, 2027, through December 31, 2027.

Background

In calendar year (CY) 2026, CalOptima Health offered health rewards to eligible members through physical gift cards for Medi-Cal and flex cards for OneCare, to enhance member health and quality outcomes. CalOptima Health provided Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visits, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests, postpartum care, osteoporosis testing, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications. Reward fulfillment is executed through multiple validation pathways, such as claims-based confirmation, member self-attestation submitted via digital forms, and provider-verified documentation.

Discussion

Health rewards may motivate members to establish primary care relationships and receive recommended preventive care and screenings. Rewards may also encourage members to complete important tests, reinforce healthy behaviors, and positively impact member experience. CalOptima Health selects rewards based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

Staff recommends maintaining the CY 2026 incentive set for CY 2027, with no changes to covered measures or reward amounts. The program categories and incentives are listed in the table below.

Proposed CY 2027 Member Incentives	
Medi-Cal	OneCare
Annual Wellness Visit - \$50	Annual Wellness Visit - \$50
Blood Lead Test 12 Months of Age - \$25	Breast Cancer Screening - \$25
Blood Lead Test 24 Months of Age - \$25	Diabetes A1c Test - \$25
Breast Cancer Screening - \$25	Diabetes Eye Exam - \$25
Cervical Cancer Screening - \$25	Health Risk Assessment - \$25
Colorectal Cancer Screening: Other Types* • Fecal occult blood test - \$15 • Fecal immunochemical test - \$15 • CT Colonography - \$25 • Flexible sigmoidoscopy - \$25	Colorectal Cancer Screening: Other Types* • Fecal occult blood test - \$15 • Fecal immunochemical test - \$15 • CT Colonography - \$25 • Flexible sigmoidoscopy - \$25
Colorectal Cancer Screening: Colonoscopy - \$50	Colorectal Cancer Screening: Colonoscopy - \$50
Diabetes A1c Test - \$25	Osteoporosis Management - \$25
Diabetes Eye Exam - \$25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications - \$25	
Postpartum Checkup - \$50	

*The reward amount will vary based on the type of colon cancer screening test completed.

Members will receive a health reward upon completing the qualifying service. At the time of budgeting, staff assumed a member participation rate of 15% for Medi-Cal and 20% for OneCare based on historical participation rates. For rewards tied to quality metrics using claims data, calculations include minimum performance thresholds and Centers for Medicare & Medicaid Services Star cut points to meet program and regulatory standards. Should the participation rates exceed these assumptions and budgeted amounts, staff will return to the CalOptima Health Board of Directors for additional funding requests at future meetings.

Staff recommends using unearned Measurement Year (MY) 2025 Pay-for-Value (P4V) Performance Program (the P4V Program) dollars to fund the Member Health Rewards Program. MY 2025 Medi-Cal P4V Program rewards have been preliminarily calculated. The total Medi-Cal P4V Program pool was \$94 million (based on 10% of professional capitation for Fiscal Year 2025-26) with \$34 million earned and \$60 million unearned. The MY 2025 OneCare P4V Program pool will be calculated in November 2026, pending results from member satisfaction surveys. Staff expects OneCare performance similar to Medi-Cal with 30% earned and 70% unearned.

Fiscal Impact

Medi-Cal:

The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2027 Medi-Cal Member Health Rewards Program is \$7.32 million. Staff anticipates that unearned funds from the MY 2025 Medi-Cal P4V Program will be sufficient to fund the program.

OneCare:

The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2027 OneCare Member Health Rewards Program is \$840,000. Staff anticipates that unearned funds from the MY 2025 OneCare P4V Program will be sufficient to fund the program.

Rationale for Recommendation

Maintaining the current program promotes preventive care, early identification, and chronic care management; strengthens primary care relationships; and supports quality performance objectives across Medi-Cal and OneCare populations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. CY 2027 Member Health Rewards for Medi-Cal and OneCare Presentation



**CalOptima
Health**

Calendar Year 2027 Member Health Rewards for Medi-Cal and OneCare

**Special Quality Assurance Committee
Meeting**

October 15, 2026

**Linda Lee, Executive Director, Quality
Improvement**

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Current 2026 Member Health Rewards Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- 11 Medi-Cal Health Rewards
- 8 OneCare Health Rewards
- Recommend continuing the program as currently designed for Calendar Year (CY) 2027

2027 Medi-Cal Program

Medi-Cal Health Reward	Reward Amount
Annual Wellness Visit	\$50
Blood Lead Test 12 Months of Age	\$25
Blood Lead Test 24 Months of Age	\$25
Breast Cancer Screening	\$25
Cervical Cancer Screening	\$25
Colorectal Cancer Screening: Colonoscopy	\$50
Colorectal Cancer Screening: Other Types • Fecal occult blood test - \$15 • Fecal immunochemical test - \$15 • CT Colonography - \$25 • Flexible sigmoidoscopy - \$25	\$15-\$25
Diabetes A1c Test	\$25
Diabetes Eye Exam	\$25
Diabetes Screening for People with Schizophrenia or Bipolar...*	\$25
Postpartum Checkup	\$50

*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications



2027 OneCare Program

OneCare Health Reward	Reward Amount
Annual Wellness Visit	\$50
Breast Cancer Screening	\$25
Colorectal Cancer Screening: Colonoscopy	\$50
Colorectal Cancer Screening: Other Types* • Fecal occult blood test - \$15 • Fecal immunochemical test - \$15 • CT Colonography - \$25 • Flexible sigmoidoscopy - \$25	\$15-\$25
Diabetes A1c Test	\$25
Diabetes Eye Exam	\$25
Health Risk Assessment	\$25
Osteoporosis Management	\$25

Summary of Fiscal Impact

- Estimated Cost at 15-20% Response Rate
 - Medi-Cal: approximately \$7.32 million
 - OneCare: approximately \$840,000

Program	CY 2026	CY 2027	Budget Difference
Medi-Cal	\$6,300,000	\$7,320,000	+ \$1,020,000*
OneCare	\$1,000,000	\$840,000	- \$160,000**

Passive health rewards were calculated based on Quality Compass Benchmarks or Star goals.

*The CY 2027 Medi-Cal budget increased due to larger denominators across multiple quality measures.

**The CY 2027 OneCare budget decreased due to the shift of the Annual Wellness Visit reward from passive claims-based processing to a member self-attestation model.





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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 15, 2026

Special Meeting of the CalOptima Health Board of Directors’ Quality Assurance Committee

Discussion Item

7. Approve Actions Related to Implementation of a Quality Improvement Grant Pilot Program

Contacts

Linda Lee, Executive Director, (657) 900-1069

Richard Lopez, MD, Chief Medical Officer (Interim), (657) 900-1483

Recommended Action

Recommend that the Board of Directors:

1. Authorize CalOptima Health staff to conduct a non-competitive, by-invitation-only, notice of funding opportunity related to the Quality Improvement Grant Pilot Program, administer grant agreements, and release award payments to participating entities.
2. Authorize allocation of up to \$500,000 from the CalOptima Health Community Care Network component of the Measurement Year 2025 Pay-for-Value Program for the Quality Improvement Grant Pilot Program.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health’s mission and purpose.

Background

CalOptima Health annually implements a Quality Improvement Health Equity Transformation Program (QIHETP) pursuant to federal and state regulatory requirements. An important component of the QIHETP is the implementation of quality improvement projects to improve performance outcomes for areas that do not meet performance goals or are high priority focuses for quality outcomes. CalOptima Health has adopted an industry standard Plan-Do-Study-Act (PDSA) quality framework to ensure a rigorous implementation and evaluation process for quality activities.

To further encourage continuous quality improvement, the CalOptima Health Board of Directors (Board) renewed the Measurement Year (MY) 2025 Pay for Value (P4V) Program by approving the MY 2026 P4V Program at its December 4, 2025, meeting. Part of the P4V Program includes a grant opportunity for contracted health networks. Under the MY 2026 P4V Program, there is no grant opportunity for providers participating in the CalOptima Health Community Care Network (CHCN).

CalOptima Health Board Action Agenda Referral
Recommend that the Board of Directors
Approve Actions Related to Implementation
of a Quality Improvement Pilot Program
Page 2

Fiscal Impact

An allocation of up to \$500,000 from the CHCN component of the MY 2025 P4V Program, approved by the Board on November 7, 2024, will fund the Pilot Program.

Rationale for Recommendation

By establishing defined quality improvement activities at FQHCs, staff anticipate marked improvement in care gap closure and quality outcomes. Implementation of standardized quality improvement projects will promote coordinating care and educating members thus addressing barriers to care.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Action

CONTRACTED / IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
	1300 Avenida Vista Hermosa, Suite 250	San Clemente	CA	92673
	22481 Aspan St, Suite A	Lake Forest	CA	92630
Friends of Family Health Center	501 S Idaho St, Suite 100, 190, 250	La Habra	CA	90631
	13152 Newport Ave, Suite B	Tustin	CA	92780
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Share Our Selves	1550 Superior Ave	Costa Mesa	CA	92627
	27725 Santa Margarita Pkwy, Suite 101	Mission Viejo	CA	92691
	1000 N Kramer Place, Suite 204	Anaheim	CA	92806
	307 Placentia Ave, Suite 107	Newport Beach	CA	92663
	1014 N Broadway	Santa Ana	CA	92701
	1650 Adams Ave	Costa Mesa	CA	92626
	2045 Meyer Place, Unit C	Costa Mesa	CA	92627
The Regents of the University of California, a California Constitutional Corporation, on behalf of the University of California Irvine Family Health Center	800 N Main St	Santa Ana	CA	92701
	2441 W La Palma Ave, Suite 100	Anaheim	CA	92801

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 15, 2026 **Special Meeting of the CalOptima Health Board of Directors'** **Quality Assurance Committee**

Discussion Item

8. Approve New CalOptima Health Policy: GG.1640 and Approve Modifications to CalOptima Health Policies: GG.1611, GG.1615, GG.1616, GG.1650, and GG.1651

Contacts

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069
Marsha Choo, Director, Quality Improvement, (714) 246-8670
Sharlee LeBleu, Director, Quality Improvement, (714) 246-8565

Recommended Action

Recommend that the Board of Directors approve CalOptima Health Policy GG.1640: Health Network Pay for Value (P4V) Program and approve revisions to the following existing CalOptima Health policies:

- Policy GG.1611: Potential Quality Issue Review Process;
- Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues;
- Policy GG.1616: Fair Hearing Plan for Licentiates;
- Policy GG.1650: Credentialing and Recredentialing of Practitioners; and
- Policy GG.1651: Assessment and Reassessment of Organizational Providers.

Background

New Quality Improvement Policy and Procedure

CalOptima Health adopts new policies to ensure organizational practices remain aligned with evolving regulatory requirements, contractual obligations, and quality-of-care expectations across Medi-Cal, OneCare, Covered California, and administrative programs. Staff develops new policies when emerging standards, program changes, or operational needs require clear, consistent guidance to support compliance, promote accountability, and advance CalOptima Health's mission to deliver high-quality, equitable care to members.

Below is a summary of new CalOptima Health Policy GG.1640: Health Network Pay for Value (P4V) Program:

CalOptima Health Policy GG.1640 establishes the structural foundation and operating requirements for CalOptima Health's Health Network P4V Program. It defines how the program is designed, measured, scored, and financially incentivized across Medi-Cal, OneCare, and Covered California product lines.

The policy incorporates state, federal, and industry-standard quality frameworks. For Medi-Cal, it integrates the Managed Care Accountability Set (referred to as MCAS), Healthcare Effectiveness Data and Information Set (referred to as HEDIS[®]), Consumer Assessment of Healthcare Providers and Systems (referred to as CAHPS), and the Integrated Healthcare Association methodology. For OneCare, the P4V program aligns directly with the Centers for Medicare & Medicaid Services Star Rating System, using Star-aligned weights and performance tiers. The Covered California P4V Program uses Quality Transformation Initiative measures and benchmarks performance against National Committee for Quality Assurance national percentiles.

Across all programs, CalOptima Health Policy GG.1640 establishes a unified scoring model based on performance attainment and year-over-year improvement, with financial incentives tied to both. The policy also specifies required corrective actions for health networks that fall below established thresholds, ensuring ongoing accountability and remediation.

Collectively, these elements position the P4V Program as a standardized, regulatory-aligned framework that supports CalOptima Health's broader strategy to improve quality outcomes, elevate member experience, and advance health equity across the delivery system.

Modifications to Existing Quality Improvement Policies and Procedures

CalOptima Health also regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, and laws, as well as CalOptima Health operations. The recommended policy changes are made as part of CalOptima Health's regular review process and consistent with regulatory requirements.

Following is a list of summary substantive changes to the policies, which are reflected in the attached policies. The list does not include non-substantive changes that may also be reflected in the redline (*i.e.*, formatting, spelling, punctuations, capitalization, minor clarifying language, and/or grammatical changes).

CalOptima Health Policy GG.1611: Potential Quality Issue Review Process defines the process and procedure for intake, investigation, reviewing, leveling (outcome score), escalation, communication and closure of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department involving Providers and Health Networks servicing Members. Below are the proposed modifications to the policy.

Policy Section	Proposed Changes
II.F	Define investigative closure as the point at which a severity outcome score has been assigned, and administrative closure as the point at which all required follow-up actions have been completed.
II.L	Add language clarifying that Potential Quality Issue (PQI) review is not a delegated function.
III.A.4.	Add language clarifying that cases involving imminent danger to an individual's health must be immediately referred to the Chief Medical Officer (CMO), their

	physician designee, or the Credentialing and Peer Review Committee (CPRC) for potential summary suspension or restriction of a contracted provider’s practice prerogatives.
III.D.2	Update the outcome score table to include clearer definitions and more descriptive explanations.
III.D.3	Add language stating that Medical Directors shall target case closure or submission of a case recommendation to CPRC within 30 days of case assignment, with an additional 30 days permitted when supplemental records are requested.
III.E.1.b	Add language stating that the Provider shall be notified that the PQI has escalated to CPRC review, and the notification shall include an offer for a written clarification/response or a call with the Medical Director assigned to the case.
III.F.4	Add language clarifying that corrective actions should be applied progressively
III.H	Clarify the frequency and scope of the reporting requirements.

CalOptima Health Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues establishes CalOptima Health’s process for initiating and managing corrective actions for Practitioners and Organizational Providers (OP) when quality-related concerns are identified. Below are the proposed modifications to this policy.

Policy Section	Proposed Changes
Name	Change the policy name to “Practitioner and Organizational Provider Corrective Action Plan of Quality Issues”.
III.B.1.	Expand the list of possible corrective actions that can be implemented by CalOptima Health.
III.C.	Add a section outlining the formal Corrective Action Plan (CAP) process, including provider communication requirements, timelines, required CAP elements, criteria for approval, and steps taken when a CAP is not approved.

CalOptima Health Policy GG.1616: Fair Hearing Plan for Licentiatees establishes CalOptima Health’s fair hearing process for Licentiatees when a hearing right is triggered by a reportable or otherwise hearing-eligible adverse action, and governs notice of action, hearing request requirements, hearing scheduling, pre-hearing exchange, hearing procedures, Judicial Review Committee (JRC) decision-making, and final action following the hearing. Below are the proposed modifications to this policy.

Policy Section	Proposed Changes
Name	Change the policy name to “Fair Hearing Plan for Licentiatees”.
All	Revise the policy to reference ‘licentiate’ rather than ‘practitioner’ throughout.
II.A.	Add the list of practitioner types included under licentiatees.
II.B-C.	Define which adverse actions do and do not trigger fair hearing rights.

CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners defines the process by which CalOptima Health evaluates and determines whether practitioners meet the

qualifications for participation in CalOptima Health programs. Below are the proposed modifications to this policy.

Policy Section	Proposed Changes
II.B. (original)	Remove the section that permits the delegation of Medi-Cal screening and enrollment activities to delegates.
II.D.	Expand credentialing decision-making authority to the CMO/designee or CPRC and added a three-year credentialing approval period.
II.I.7.	Expand the practitioner types subject to credentialing and recredentialing.
II.K.3-6.	Strengthen minimum qualification review criteria to include fraud, waste, and abuse history, criminal history, liability claims history, and exclusion/sanction/debarment review.
II.T.	Clarify credentialing decision and notification timelines, including application expiration if no decision is made within six (6) months.
III.A.1-4.	Revise primary source verification and screening requirements, including additional verification elements and updated cross-references.
III.A.5. / III.B.5.	Add standardized documentation requirements for credentialing file verification.
III.C.	Expand practitioner rights related to review of information and status requests.
III.D.4-6.	Revise CPRC review and decision standards, including clean-file criteria, review process, and decision notification requirements.
III.F.	Clarify post-approval information-sharing and provider-directory update responsibilities.
III.H.	Expand required screening databases and ongoing monthly monitoring requirements.
Attachment A	Retire Attachment A, CalOptima Health Primary Source Verification Table.

CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, and eligibility to participate in CalOptima Health programs. Below are the proposed modifications to this policy.

Policy Section	Proposed Changes
II.D.	Clarify assessment/reassessment oversight and added a three-year initial credentialing period.
II.H.3-6.	Expand Medi-Cal screening criteria for providers without a state enrollment pathway.
III.A.2.c.	Expand acceptable business documentation to include a business tax certificate.
III.A.2.g.	Expand adverse-action screening across Medicare, Medi-Cal, and other federal/state health care programs.
III.B.1.f.	Apply the expanded adverse-action screening standard to Intermediate Care Facility for Developmentally Disabled assessments.

III.D.3.a.	Revise clean-file criteria to add specific malpractice and National Practitioner Data Bank thresholds.
III.D.3.a.ii.	Revise CPRC's role from approval to review of clean files.
III.D.5.a.i-iii.	Expand approval outcomes, including time-limited approval and approval with conditions.
III.E.3.	Clarify that CalOptima Health does not currently perform Medi-Cal screening and enrollment directly.

Fiscal Impact

The recommended actions are operational in nature and have no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, rules, and accreditation standards, CalOptima Health staff recommends that the Board of Directors approve and adopt the new policy and procedure and revised policies and procedures. For existing CalOptima Health policies, the updated policy and procedure will supersede prior versions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [CalOptima Health Policy GG.1640: Health Network Pay for Value \(P4V\) Program](#)
2. [CalOptima Health Policy GG.1611: Potential Quality Issue Review Process](#)
3. [CalOptima Health Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues](#)
4. [CalOptima Health Policy GG.1616: Fair Hearing Plan for Licentiates](#)
5. [CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners](#)
6. [CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers](#)
7. [Quality Policy Updates Presentation](#)

Policy: GG.1640
 Title: **Health Network Pay for Value (P4V) Program**
 Department: Quality Analytics
 Section: Not Applicable

CEO Approval: /s/

Effective Date: TBD
 Revised Date: TBD

Applicable to: ☐ Administrative
☒ Covered California
☒ Medi-Cal
☒ OneCare
☐ PACE

I. PURPOSE

This policy defines requirements and processes for CalOptima Health's Health Network Pay for Value (P4V) Program to incentivize quality performance, improve health outcomes, and promote health equity through structured financial rewards and corrective actions.

II. POLICY

- A. CalOptima Health shall implement P4V programs for Medi-Cal, OneCare, and Covered California Health Networks and Primary Care Providers (PCPs) for each measurement year (MY).
- B. This program utilizes Integrated Healthcare Association (IHA) scoring methodology for Medi-Cal and OneCare, and benchmark comparison for Covered California.
- C. Incentives are based on attainment and improvement scores, with corrective actions required for underperformance in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.
- D. Funding is allocated through Board-approved funds for each measurement year.
- E. Unearned incentive dollars are redirected to quality improvement initiatives and grants in accordance with CalOptima Health Policy AA.1400: Grant Management.

III. PROCEDURE

A. Program Components:

1. Medi-Cal Pay for Value Program

- a. The Medi-Cal P4V Program utilizes the DHCS Managed Care Accountability Set (MCAS) measures, including Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures.
- b. Health Networks are scored using the Integrated Healthcare Association (IHA) methodology, which calculates both attainment and improvement points.

- c. Attainment points range from one (1) to ten (10) based on performance between the 50th and 95th percentiles, while improvement points will range from zero (0) to ten (10) based on year-over-year progress.
- d. The greater of the two scores will be used for each measure.
- e. HEDIS measures are weighted at 1.0, and CAHPS measures will be weighted at 1.5.
- f. Health Networks that score below the 50th percentile will be required to submit an improvement plan to CalOptima Health.
- g. DHCS quality withhold penalties will be deducted from earned P4V payments.

2. OneCare Pay for Value Program

- a. The OneCare P4V Program is aligned with the Centers for Medicare and Medicaid Services (CMS) Star Rating system and include select Part C and Part D measures.
- b. Performance is assessed using a Star-based scale, with attainment and improvement points calculated according to CMS Star cut points.
- c. HEDIS process measures are weighted at one (1), CAHPS member experience measures at two (2), and outcome measures at three (3).
- d. Incentive payments will be based on overall Star performance, ranging from 0% for ratings below 3.0 Stars to 100% for ratings of 5.0 Stars.
- e. Health Networks that score below 3.0 Stars will be required to submit an improvement plan.

3. Covered California Pay for Value Program

- a. The Covered California P4V Program was developed from the Covered California Quality Transformation Initiative (QTI) measures.
- b. Performance is assessed by comparing Health Network rates to National Committee for Quality Assurance (NCQA) Quality Compass National Exchange percentiles.
- c. Incentive payments are awarded based on percentile achievement, with 100% of the incentive earned at the 75th percentile and 50% earned at the 50th percentile.
- d. All measures will be weighted equally.

IV. ATTACHMENT(S)

- A. CalOptima Health Measurement Year (MY) 2026 Pay for Value Programs Addendum

V. REFERENCE(S)

- A. CalOptima Health Board Action Agenda Referral (November 13, 2025)
- B. CalOptima Health Policy AA.1400: Grant Management
- C. CalOptima Health Policy GG.1205: HEDIS Data Collection and Reporting
- D. CalOptima Health Policy GG.1634: Quality and Performance Improvement Projects
- E. CalOptima Health Policy GG.1637: Assessing Member Experience
- F. CalOptima Health Policy HH.2002: Sanctions
- G. CalOptima Health Policy HH.2005: Corrective Action Plan

- H. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-004: Quality Improvement and Health Equity Transformation Requirements (Supersedes APL 19-017)
- I. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-007: Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions (Supersedes APL 23-012)
- J. Title 42 Code of Federal Regulations (CFR) §§ 438.310, 438.330, 438.358

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1640	Health Network Pay for Value (P4V) Program	Covered California Medi-Cal OneCare

1 IX. GLOSSARY

2

Term	Definition
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)	A standardized survey that measures members' experiences with health care services and providers.
Centers for Medicare and Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered California Quality Transformation Initiative (QTI)	A program that incentivizes quality improvement among Qualified Health Plans participating in Covered California.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medical Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Healthcare Effectiveness Data and Information Set (HEDIS®)	A widely used set of performance measures developed by NCQA to evaluate health care quality.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, 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.
Integrated Healthcare Association (IHA) Methodology	A standardized scoring approach used to calculate quality ratings based on attainment and improvement.
Minimum Performance Level (MPL)	The benchmark rate established by DHCS or CMS that health networks must meet or exceed for specific quality measures.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Pay for Value (P4V) Program	A performance-based incentive program that is designed to reward health networks and providers for achieving quality and equity goals.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Star Ratings	A CMS quality rating system that evaluates health plans on a scale of 1 to 5 Stars based on clinical quality, member experience, and other measures.

3

CalOptima Health Measurement Year (MY) 2026 Pay for Value Programs Addendum

Program Component Appendix

MY 2026 Medi-Cal P4V Program Components

The Medi-Cal P4V Program incentivizes performance on all HEDIS® measures included in the DHCS Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V Program also includes incentives for CAHPS member satisfaction measures. Contracted HNs and PCPs are eligible to participate in the Medi-Cal P4V Program.

MY 2026 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2026 MCAS measure set.

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

CalOptima Health Measurement Year (MY) 2026

Pay for Value Programs Addendum

- Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.
2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
 - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
 - Scoring
 - Attainment Points
 - Scale of 1-10 points
 - Points based on performance between 50th percentile and 95th percentile.
 - $1 + \left(\frac{(MY2026 \text{ Rate} - 50th \text{ Percentile})}{((95th \text{ Percentile} - 50th \text{ Percentile})/9)} \right)$
 - Improvement Points
 - Scale of 0-10 points
 - Points reflect performance in the prior year compared to the current year.
 - $\left(\frac{(MY2026 \text{ Rate} - MY2025 \text{ Rate})}{((95th \text{ Percentile} - MY2025 \text{ Rate})/10)} \right)$
 3. Prior year (MY2025) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.
 4. Measure weighting
 - HEDIS measures weighted 1.0
 - CAHPS measures weighted 1.5
 5. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
 6. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.
 7. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.
 8. DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.

CalOptima Health Measurement Year (MY) 2026 Pay for Value Programs Addendum

OneCare P4V Program Components

The OneCare P4V Program focuses on select CMS Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Contracted HNs and PCPs are eligible to participate in the OneCare P4V Program.

MY 2026 OneCare P4V Program Components

Alignment with the CMS Star program and the following components: CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:

1. Utilize a subset of CMS Star measures

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease
	Care Coordination
Part C Member Experience	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
Part D	Rating of Health Network
	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN

CalOptima Health Measurement Year (MY) 2026 Pay for Value Programs Addendum

- Attainment and Improvement score calculated for each measure. The better of the two scores is used.
- Scoring
 - Attainment Points
 - Scale of 1-5 points
 - Points based on performance between 3-Star and 5-Star cut points.
 - $1 + \left(\frac{(MY2026 \text{ Rate} - 3 \text{ Star cut point})}{((5 \text{ Star cut point} - 3 \text{ Star cut point})/4)} \right)$
 - Improvement Points
 - Scale of 0-5 points
 - Points reflect performance in the prior year compared to the current year.
 - $\left(\frac{(MY2026 \text{ Rate} - MY2025 \text{ Rate})}{((5 \text{ Star cut point} - MY2025 \text{ Rate})/5)} \right)$
- 3. MY2026 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2027 in the 2028 Star Rating Technical Notes.
- 4. Measure weighting
 - HEDIS process measures weighted 1
 - CAHPS measures weighted 2
 - Outcome measures weighted 3
- 5. Apply a program funding methodology of \$20 PMPM
- 6. Available Incentive Pool: the OneCare incentive pool will be determined by each HN's Stars performance as described in the table below. Actual OneCareP4V Program incentives will be based on performance as described in this section.

OneCare P4V Performance	MY2026 Incentive Percentage SY2028
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY = Star rating display year

- 7. Performance incentive allocations will be distributed upon final calculation and validation of each HN's performance
- 8. HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.

Covered California P4V Program Components

CalOptima Health Measurement Year (MY) 2026

Pay for Value Programs Addendum

The Covered California P4V Program focuses on measures included in the Quality Transformation Initiative (QTI). Contracted HNs are eligible to participate in the Covered CA P4V Program.

MY 2027 Covered CA P4V Program Components

Alignment with the Covered CA Quality Transformation Initiative (QTI) and the following components

1. CalOptima Health will adopt the 2027 QTI measures for the MY2027 P4V Program.

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

2. Utilize an attainment scoring methodology where rates that meet designated benchmarks qualify for percentages of incentives per measure
3. MY2026 NCQA Quality Compass National Exchange percentiles used as benchmarks
4. Measures will be weighted equally
5. Establish program funding at ten percent (10%) of professional capitation (base rate only)
6. Covered CA P4V incentives will be based on performance compared to benchmarks as described below:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance

Policy: GG.1611
 Title: **Potential Quality Issue Review Process**
 Department: Quality Improvement
 Section: Not Applicable

CEO Approval: /s/

Effective Date: 12/01/1999

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☐ PACE

I. PURPOSE

This policy defines the process and procedure for intake, investigation, reviewing and processing, leveling (outcome score), escalation, communication and closure of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department for any Provider servicing Members involving Providers and Health Networks servicing Members. This policy also identifies when matters are referred to related policies governing corrective action, fair hearing, summary suspension or restriction, and external reporting.

II. POLICY

- A. CalOptima Health departments, Health Networks (HNs) and Providers shall refer a PQI to the CalOptima Health QI Department for review and investigation when information suggests that a Member's Quality of Care (QOC), Quality of Service (QOS), patient safety, or related care process may have been compromised.
 1. Quality-of-care Grievances are processed under applicable Grievance requirements and routed for PQI review when clinical quality review is indicated, in accordance with Policies: CC.1201: Member Grievance, HH.1102: Member Grievance, and MA.9002: Enrollee Grievance Process.
- B. The QI Department shall serve as the single point of intake for PQI cases and shall log a PQI in CalOptima Health's care management system and appropriately. Appropriately trained and qualified staff, including QI Nurses and CalOptima Health Medical Directors, shall review all PQIs. Goals for the PQI review include improving Member outcomes, reducing errors, and/or enhancing efficiency.
- C. The QI Department shall manage the PQI process through the following stages: intake and triage, information gathering, clinical and operational review, severity scoring, escalation when indicated, action implementation, provider notification, and case closure.
- D. The QI Department shall use provider-facing communications at key process points, including when records or responses are requested, when a case is escalated for Medical Director or Credentialing and Peer Review Committee (CPRC) review, when corrective action is required, and when the case is closed.
- E. The QI Department shall conduct antit timely investigation on the of each PQI and obtain pertinent documentation needed to evaluate the issue. CalOptima Health shall meet the internal target for

investigative closure within one hundred twenty (120) calendar days of receipt of the PQI, unless the case needs to be expedited as needed to conduct the for imminent member-safety risk or the case complexity, confidentiality limitations, external review needs, or related proceedings require additional time.

F. A case shall be considered:

1. Closed for investigation- when a severity outcome score has been assigned;
2. Administratively closed when all required follow-up actions, including monitoring or corrective action verification, have been completed.

G. CalOptima Health's Chief Medical Officer (CMO) or Designee may refer PQI cases to the CalOptima Health ~~Credentialing and Peer Review Committee (CPRC)~~ for evaluation and action, pursuant. Cases assigned Severity Outcome Score 3 shall be presented to CPRC. Other cases may be presented at the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP)-Medical Director's discretion.

~~E. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank, and, as applicable, CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant Agency within fifteen (15) days after the effective date of an action of the CPRC, as further described in CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.~~

~~F. The QI Department shall track, trend, and analyze Provider and Health Network PQI data by issue, action(s), and level of severity monthly to identify emerging patterns.~~

- ~~a. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.~~

~~C.A. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary.~~

~~H. The QI Department shall prepare a summary report of all QI case activities monthly and submit the report for review to the CalOptima Health CPRC.~~

~~I. The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC) and to the Board of Directors Quality Assurance Committee (QAC) quarterly.~~

~~J.H.~~ CalOptima Health shall maintain confidentiality of QI case review information, in accordance with this policy and applicable privacy and confidentiality laws. When a case is designated confidential because a Member chooses anonymity, CalOptima Health shall limit disclosures and blind Member-identifying information in provider-facing communications to the extent practicable and permitted by law.

I. The QI Department shall track, trend, and analyze PQI data by issue, action, and severity level monthly to identify emerging patterns, inform quality improvement activities, and support referral of repeated or significant issues for further review. Analysis and findings shall be reported to CPRC.

J. When the outcome of a PQI review leads to corrective action, summary suspension or restriction, fair hearing rights, or external reporting obligations, CalOptima Health shall follow the applicable requirements in Policies GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues, GG.1658: Summary Suspension or Restriction of Practitioner Participation in

CalOptima Health's Network, GG.1616: Fair Hearing Plan for Licentiates, and GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

K. CalOptima Health maintains a formal, written Quality Improvement Health Equity Transformation Program (QIHETP) approved by CalOptima Health's Quality Assurance Committee (QAC) of the Board and overseen through the CPRC and clinical leadership. The PQI process is a component of this governance structure.

L. CalOptima Health does not delegate PQI review and retains direct responsibility for performance of these activities.

III. PROCEDURE

J. PQI cases given a severity level 3 shall send a letter per the following criteria as the recommendation of the Medical Director or CPRC:

1. The Providers contracted with CCN shall receive a letter outlining the findings of the investigation.
2. The Providers who are not contracted with CCN but are contracted with a CalOptima Health Network, shall receive a letter and a letter may be sent to their contracted Health Network requesting its review of the case and a request to provide a response to CPRC at the conclusion of their investigation.
3. For non-contracted Providers, a non-805 reportable letter may be submitted to the State Licensing Board requesting its review of the issue identified by CPRC.

III. PROCEDURE

A. Case Referral and Identification Intake

1. In addition to PQI referrals to CalOptima Health made by Providers and Health Networks, a PQI may also be identified and referred to the QI Department from multiple internal sources. Internal sources, include but are not limited to by CalOptima Health departments, QIHEC committees and subcommittees, and Grievance activity, monitoring activity, and other QOC-related activities such as monitoring, analyzing, and improving processes to enhance Member outcomes, reduce errors, or improve efficiency.
2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review. This includes declined Grievances where the Member declines to file a Grievance, but a QOC issue is identified in the complaint.
3. Supporting documentation (e.g., including correspondence, Grievances, claims data, case management notes), shall accompany the referral.
2. Any entity whenever available. The referring party shall indicate whether the Member requests anonymity. CalOptima Health reserves the right to notify any appropriate governing, oversight, or regulatory body regarding concerns about any Provider delivering care to CalOptima Health Members.
 - a. Upon receipt of a PQI referral, a PQI case shall specify whether the Member chooses to remain anonymous.

1 B. Process, Review, and Evaluation of PQI Cases

2
3 4.3. PQI cases shall be opened by the CalOptima Health QI Department PQI team to review QOC
4 issues, system issues, and/or administrative issues. QI Department. PQI cases shall be documented
5 in CalOptima Health's care management system.

6
7 a. If the Member chooses to remain anonymous, the case will be flagged as confidential in the
8 care management system.

9
10 4. Cases identified as having imminent danger to the health of any individual shall be immediately
11 referred to the CMO, their physician Designee, or CPRC to summarily suspend or restrict a
12 contracted Provider's practice prerogatives if needed, in accordance with Policy GG.1658:
13 Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network.

14
15 B. Information Gathering, Provider Response, and Initial Review

16
17 1. The QI Nurse shall RN shall conduct an initial review of the PQI case and determine the
18 additional information needed to conduct a full investigation.

19
20 1-2. The QI Department shall notify the Provider that a PQI has been opened, the issue related to the
21 PQI and request pertinent medical records and a, as applicable, a written response to the PQI
22 from the appropriate Provider(s) and/or Health Network that rendered medical services or were
23 involved in rendering medical service(s) related to the PQI. in the PQI. Requests shall specify the
24 information sought, the requested submission date, the method of submission, and the CalOptima
25 Health contact for procedural questions.

26
27 i. Medical records Unless otherwise specified due to urgency, confidentiality, or regulatory
28 requirements, Providers and Health Networks shall be given a standard response may or
29 may not be able to be obtained timeframe established by department procedure, with
30 extension requests considered for confidential cases to maintain the Member's
31 anonymity.

32
33 ii. If a Provider or Health Network fails good cause. Failure to respond:

34
35 2-3. CalOptima Health's QI Department, or submit requested information/documentation may result in consultation
36 with a CalOptima Health Medical Director, may take any review based on available information and all reasonable
37 actions it deems to be in the best interest of the Member may lead to further action, including the issuance of a
38 corrective action plan, pursuant to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and
39 Organizational Providers request, when appropriate.

40
41 3-4. Data may also be collected from The QI Department may collect and review surveys, incident reports,
42 claims data, grievances, and other sources relevant internal or external information to assess QOC,
43 QOS, and provider performance.

44
45 4. CalOptima Health's QI Department may deem it appropriate to deploy CalOptima Health's
46 copying vendor to copy and obtain medical records.

47
48 5. CalOptima Health's If Member anonymity limits the ability to obtain records or provider responses, the
49 QI Department shall document those limitations and proceed using the information reasonably
50 available.

51
52 4-6. The QI Department shall analyze medical records and other data and will target case investigative closure within
53 one hundred and twenty (120) calendar days of receipt of the PQI. The case will be considered closed when it is

~~given an outcome score~~ PQI receipt. PQIs that are declined grievances shall receive preliminary Medical Director review within thirty (30) calendar days after the PQI is opened.

C. Nurse Review

1. The QI Nurse RN shall conduct a primary review of all PQI cases.

2. QI Nurses may close cases when ~~the following~~:

~~a. The case~~ is determined:

a. ~~The case is deemed to be~~ service-related only; and/or

b. No QOC or ~~Quality of Service (QOS)~~ issue is identified.

~~b. Declined Grievances shall be preliminarily reviewed by a CalOptima Health Medical Director within thirty (30) days of when the PQI is opened.~~

2.3. If ~~the~~ QI Nurse RN does not identify a QOC issue, ~~the case will be reviewed by a second QI Nurse RN, and if shall review the case.~~ If the second QI Nurse RN concurs, the case ~~will~~ may be ~~given an outcome score, designated scored, and closed~~ with the Action~~action~~ of “No Further Action Required” and/or “Track and Trend” ~~and the case will be closed.~~”

3.4. If the QI Nurse identifies a QOC issue, the case shall be referred to ~~and reviewed by the~~ CalOptima Health Medical Director, ~~who must address~~ for review. The Medical Director shall ~~assess~~ service elements, including accessibility, availability, and continuity of care, and assess whether the provision and utilization of services meet professionally recognized standards of practice. ~~Based upon the outcome of the review, the reviewer shall assign an outcome score that reflects the severity of the issue and determine if any further action will be taken. The case may be closed by the CalOptima Health Medical Director or be presented to CalOptima Health CPRC for further review and consideration(s).~~

~~a. Cases assigned severity Outcome Score 3 will be presented to CPRC for consideration and recommendation of action.~~

D. Other cases may be presented to CPRC upon Medical Director Review and Severity Scoring

1. The Medical Director shall conduct a secondary review of all QOC cases. The Medical Director shall assign an outcome score that reflects the severity of the issue and determine whether further corrective action is warranted, in accordance with Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues.

1.2. CalOptima Health ~~Medical Director's discretion~~ shall use the following outcome categories:

Outcome	Definition	Description of Outcome Score
0	<u>No Impact / No Risk:</u> <u>Care appears appropriate.</u> No Quality-of-Care or Quality-of-Service issue identified.	<u>No provider error or lapse in clinical judgment.</u> <u>Member received appropriate care without delay.</u> <u>No documentation inaccuracies.</u> <u>No follow-up action required beyond</u>

Outcome	Definition	Description of Outcome Score
1	<u>Mild clinical judgment</u> <u>Low Impact / Minimal Risk:</u> <u>Minor opportunity for improvement. Potential for or operational issue with or without an actual, minor adverse outcome to member.</u>	• <u>Slight deviation from best practice or documentation expectations.</u> • <u>Isolated, non-recurrent provider behavior.</u> • <u>No harm or care disruption.</u> • <u>Corrected at provider or supervisor level.</u>
2	<u>Moderate clinical judgment</u> <u>Moderate Risk:</u> <u>Moderate opportunity for improvement. Care deemed below standard or operational issue with care, or without an potential for or actual moderate adverse outcome.</u>	• <u>Moderate deviation from clinical guidelines or evidence-based practice.</u> • <u>Recurring provider documentation errors.</u> • <u>Member experienced a minor delay in care or care coordination.</u> • <u>Requires targeted provider feedback, re-training, or corrective action.</u>
3	<u>High Impact / Significant Risk:</u> <u>Significant opportunity for improvement. Care deemed below standard of care, or potential for or actual significant adverse outcome to Member.</u>	• <u>SevereMajor deviation from clinical judgmentpractice guidelines or operational issue with standards of care.</u> • <u>Member experienced care disruption or without an temporary adverse outcome.</u> • <u>Provider error impacted diagnostic accuracy or care timeliness.</u> • <u>Requires immediate escalation and</u>
S0	<u>Service Only / Unverified:</u> <u>Service-related issue, unable to verify.</u>	• <u>No confirmable deviation in provider service or interaction.</u> • <u>Member dissatisfaction is noted, but objective evidence is absent.</u> • <u>No demonstrated impact on care, safety, or required services.</u>
S1	<u>Service Only Verified:</u> <u>Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.</u>	• <u>Service lapse confirmed (communication, respect, timeliness, professionalism).</u> • <u>No clinical impact or harm.</u> • <u>May affect member satisfaction or experience.</u>

3. The Medical Director shall target a case investigative closure or case recommendation to CPRC within 30 days of the PQI case assignment. An additional 30 days is allotted if additional records or documentation is requested by the Medical Director.

4. The case may be closed for investigation by the CalOptima Health Medical Director or be referred and presented to CalOptima Health CPRC for further review and consideration(s).

a. Cases scored 0, S0, or S1, 1 and 2 may be closed by the Medical Director without CPRC review or they may be escalated to CPRC at the Medical Director's discretion.

b. Cases scored 3 will be presented to CPRC.

E. CPRC Review

1. PQI cases with a recommended outcomes score of 3 shall be presented to the CPRC by a Medical Director following completion of a comprehensive case review.

- a. A comprehensive case review shall include an opportunity for the provider to provide a written clarification/response or a call with the Medical Director assigned the case to correct factual misunderstandings, submit context, describe corrective measures already taken and propose remediation.
 - b. The Provider shall be notified that the PQI has escalated to CPRC review and the notification shall include an offer for a written clarification/response or a call with the Medical Director assigned the case.
2. CPRC shall discuss presented cases and choose to adopt the recommended outcomes score or assign a different outcome score that reflects the severity of the issue. CPRC is chaired by the CMO or physician designee.
 3. PQI cases assigned a severity score of 3 by CPRC shall trigger issuance of a letter to the Provider and, if appropriate, a letter shall be sent to the Provider's contracted Health Network(s) outlining the investigation's findings. CalOptima Health reserves the right to notify any appropriate governing, oversight, or regulatory body regarding concerns about any Provider delivering care to CalOptima Health Members.

F. External Review, Actions, and Provider Notification

~~6.—CalOptima Health shall utilize an external review entity when the following occurs:~~

~~1.—Aa specific specialty is required for PQI review and the specialty is not represented by a CalOptima Health Medical Director or when a=~~

1. ~~A second opinion is determined to be needed.~~
2. A CalOptima Health CMO, Medical Director or CPRC may recommend and approve further corrective action, including but not limited to: if warranted, in accordance with Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues.
 - a. ~~A corrective action, which may require~~Once the PQI review process is completed, a PQI Provider to attend a course, provide training to their staff, and/or update policies and procedures;
 3. ~~An educational or best practice resolution letter, which may reference an All Plan Letter or other regulatory requirement, a CalOptima will be sent to the Provider or Health policy, and/or national standard of practice; Network.~~
 - b. ~~An on-site audit of the facility and/or medical records;~~
 - c. ~~Medical records review;~~
 - d. ~~Referral to CalOptima Health Fraud, Waste & Abuse, Contracting, or another internal department;~~
 - e. ~~Referral to a regulatory Agency, including but not limited to a~~The PQI Provider resolution letter shall state licensing Agency, the California Department of Public Health, and/or The Joint Commission.
- a. ~~Require other~~outcome at a level appropriate action(s) as recommended by to the CPRC, circumstances, identify required follow-up to and including the recommendation actions if

1 any, and, for administrative or for cause termination per CalOptima Health Policy GG.1616:
2 Fair Hearing Process confidential cases, blind Member-identifying information.

3
4 4. Actions should be applied progressively when appropriate, taking into account patient safety risk,
5 severity, repetition, provider responsiveness, and contractual or regulatory requirements.

6
7 2.5. The QI Nurse will implement the action(s) under the guidance of a CalOptima Health Medical
8 Director and report back to a CalOptima Health Medical Director when the action is completed.

9
10 7. Once the PQI review process is completed, a resolution letter will be sent to the Provider or
11 Health Network.

12
13 6. The QI Department shall document all PQI decisions, activity and actions in the Provider's PQI
14 file in care management system, CalOptima Health's PQI system, and shall include a summary of
15 the case review findings in the Provider's Credentialing file in accordance with CalOptima Health
16 Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment
17 and Reassessment of Organizational Providers.

18
19 a. If the case was a confidential case, the Member information will be blinded in the Provider/
20 or Health Network resolution letter.

21
22 3.7. If the Provider/Health Network disagrees with the determination, the Provider/ or Health Network
23 may notify CalOptima Health by contacting contact the QI Department and/or by filing a
24 complaint pursue the applicable provider compliance process pursuant to CalOptima Health
25 Policies CC.1202: CalOptima Health Provider Complaint, HH.1101: CalOptima Health Provider
26 Complaint, and MA.9006: Contracted Provider Complaint Process.

27
28 8. If a Provider disagrees with the determination of an adverse action for Medical Disciplinary
29 Cause or Reason requiring a reportable adverse action, the Provider shall be provided hearing
30 rights, in accordance with Policy GG.1616 Fair Hearing Plan for Licentiates.

31 32 G. Provider Notification and Case Closure

33
34 1. Once the case is leveled with an outcomes score, the case is investigatively closed, and a letter
35 will be sent to the Provider or Health Network notifying them that the investigation is closed.

36
37 2. Once all follow-up actions, including monitoring or corrective action verification, are completed,
38 the case is administratively closed, and a letter will be sent to the Provider or Health Network
39 notifying them that the PQI case is closed.

40 41 H. Trending and Reporting Requirements and Follow-up Actions

42
43 1. CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant
44 agency within fifteen (15) days after the effective date on which any of the following occurs as a
45 result of an action of the CPRC per CalOptima Health Policy GG.1658: Summary Suspension or
46 Restriction of Practitioner Participation in CalOptima Health's Network:

47
48 a. A Licentiate's application for staff privileges or membership is denied or rejected for a
49 medical disciplinary cause or reason.

50
51 b. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a
52 medical disciplinary cause or reason.

~~e. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more within any twelve (12) month period, for a medical disciplinary cause or reason.~~

~~2. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank in accordance with CalOptima Health policy CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.~~

1. The QI Department shall use statistical methods and quality improvement models to identify trends, gaps, and potential cause(s) of issue(s) to generate trend reports of PQI cases, patterns, and causes of PQIs issues and shall report to the CPRC, which includes the CMO, at least every six (6) months.

~~b.a. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.~~

2. The QI Department shall submit a report to CPRC of all QOC Practitioner specific complaint cases referred to QI by the GARS Department, evaluating the Practitioner's history of complaints, every six (6) months.

~~a. The QI Department shall submit a monthly report to CPRC of all PQI case findings of PQIs closed the previous month, trend reports, and recommended actions to the CPRC quarterly. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.~~

3. The QI Department shall follow up on all actions that the CPRC recommends, track compliance (including requesting evidence that corrective actions have been implemented), and report to the CPRC.

4. The CalOptima Health QIHETC shall submit quarterly summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' QAC, in accordance with the CalOptima Health QIHETP Plan.

~~e.a. The QI Department may extract relevant information from case reviews, including those where no quality issues were identified, for trending, future study, and monitoring impact on health care quality, continuously assessing improvements, and to adjust strategies as needed.~~

~~b. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.~~

~~c. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary~~

~~d. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.~~

2. The QI Department shall follow up on all actions recommended by CPRC, track compliance, request evidence of implementation when required, and report status to CPRC until the action is complete.

3. Reporting Requirements

a. Monthly: The QI Department shall report all PQI cases, closed the previous month, which includes identified adverse events. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.

~~5. The QI Department shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.~~

a.b. Quarterly: The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

c. Quarterly: The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC). Each quarter, the QIHEC shall submit summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP) Plan.

d. At least semi-annually (every 6 months): QI reports to CPRC on all Practitioner-specific Member complaint cases referred to QI (QOC) by the GARS Department, including an evaluation of the history of complaints for all Practitioners.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. California Business and Professions Code, §805, 805.01, 809(b) and 1000
- B. California Health and Safety Code §-1370
- C. CalOptima Health ~~2025~~ Quality Improvement Health Equity Transformation ~~Plan~~ Program (QIHETP)
- D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
- F. CalOptima Health Contract with Covered California
- G. Covered California Physician Group Services Contract
- ~~H.~~ CalOptima Health Policy CC.1201: Member Grievance
- ~~H.I.~~ CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
- ~~I.J.~~ CalOptima Health Policy GG.1615: ~~Corrective Action Plan for~~ Practitioners and Organizational Providers Corrective Action Plan for Quality Issues
- ~~I.K.~~ CalOptima Health Policy GG.1616: Fair Hearing Process Plan for Licentiatees
- ~~K.L.~~ CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
- ~~L.M.~~ CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
- ~~M.N.~~ CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
- ~~N.O.~~ CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
- ~~O.P.~~ CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
- Q. CalOptima Health Policy HH.1102: Member Grievance
- ~~P.R.~~ CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
- S. CalOptima Health Policy MA.9002: Enrollee Grievance Process

~~Q.T.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and “Your Rights” Templates (Supersedes APL 17-006) (Revised 08/31/2022)
~~R.U.~~ Peer Review Conclusion Letter
~~S.V.~~ Title 22, California Code of Regulations (C.C.R.), §-51051
~~T.W.~~ Title 28, California Code of Regulations (C.C.R.), §§-1300.70(a)(1) and (3), 1300.70(b)(1)(B) and (C), 1300.70(b)(2)(C), 1300.70(c)
~~U.X.~~ Title 42, Code of Federal Regulations (C.F.R.), §-422.152 and 438.330

REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use

BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/06/2026	Regular Meeting of the CalOptima Board of Directors

REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2023	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	04/01/2025	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	05/01/2025	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised	08/01/2026	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
<u>Revised</u>		<u>GG.1611</u>	<u>Potential Quality Issue Review Process</u>	<u>Covered California</u> <u>Medi-Cal</u> <u>OneCare</u>

GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
<u>805.01 Report</u>	<u>The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805.01 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:</u> <u>1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.</u> <u>2. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.</u> <u>3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason, therefore.</u> <u>A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity – §805(a)(1)(B)(iv)</u>
Agency	The relevant state licensing agency having regulatory jurisdiction over the Licensates.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

Term	Definition
	<u>OneCare</u> : The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The CPRC is CalOptima Health's peer review body and makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all Practitioners and Organizational Providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee.
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.
Grievance	<u>Covered California</u>: 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. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Licentiate	~~Physician~~ <u>"Licentiate" is defined in Section 809(b) of the California Business and Professions Code as a physician</u> and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, ~~or dentist, licensed midwife, physician assistant, or nurse practitioner practicing pursuant to BPC §§ 2837.103 or~~

Term	Definition
	~~2837.104. Licentiate also includes a person and persons~~ authorized to practice medicine pursuant to ~~BPC §§~~ <u>Business and Professions Code Section</u> 2113 or 2168. <u>“Licentiate” is defined in Section 805 and 805.01 to include licensed midwives, physician assistants, and nurse practitioners for reporting.</u>
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	<u>Medi-Cal:</u> Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, end-stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. <u>OneCare:</u> Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of “Peer Review Body” in Business and Professions Code Section 805(a)(1)(b).
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member’s quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	~~For purposes of this Policy, Practitioner means a “Licentiate” as that term is defined in BPC § 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to BPC §§ 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a state to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 and its implementing regulations.~~

Term	Definition
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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)	A committee facilitated by CalOptima Health's Medical Director, or the Medical Director's Designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	<u>Medi-Cal</u>: Defined as, adequate access and availability to primary, behavioral health services, specialty health care, and long-term services and supports (LTSS) Providers and services; continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum. <u>OneCare</u>: Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Providers is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs.

Policy: GG.1611
Title: **Potential Quality Issue Review Process**
Department: Quality Improvement
Section: Not Applicable

CEO Approval: /s/

Effective Date: 12/01/1999

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☐ PACE

1 **I. PURPOSE**

2
3 This policy defines the process and procedure for intake, investigation, reviewing, leveling (outcome
4 score), escalation, communication and closure of a Potential Quality Issue (PQI) referred to the
5 CalOptima Health Quality Improvement (QI) Department involving Providers and Health Networks
6 servicing Members. This policy also identifies when matters are referred to related policies governing
7 corrective action, fair hearing, summary suspension or restriction, and external reporting.
8

9 **II. POLICY**

10
11 A. CalOptima Health departments, Health Networks (HNs) and Providers shall refer a PQI to the
12 CalOptima Health QI Department for review and investigation when information suggests that a
13 Member's Quality of Care (QOC), Quality of Service (QOS), patient safety, or related care process
14 may have been compromised.

- 15
16 1. Quality-of-care Grievances are processed under applicable Grievance requirements and routed for
17 PQI review when clinical quality review is indicated, in accordance with Policies: CC.1201:
18 Member Grievance, HH.1102: Member Grievance, and MA.9002: Enrollee Grievance Process.
19

20 B. The QI Department shall serve as the single point of intake for PQI cases and shall log a PQI in
21 CalOptima Health's care management system. Appropriately trained and qualified staff, including QI
22 Nurses and CalOptima Health Medical Directors, shall review all PQIs.
23

24 C. The QI Department shall manage the PQI process through the following stages: intake and triage,
25 information gathering, clinical and operational review, severity scoring, escalation when indicated,
26 action implementation, provider notification, and case closure.
27

28 D. The QI Department shall use provider-facing communications at key process points, including when
29 records or responses are requested, when a case is escalated for Medical Director or Credentialing and
30 Peer Review Committee (CPRC) review, when corrective action is required, and when the case is
31 closed.
32

33 E. The QI Department shall conduct timely investigation of each PQI and obtain pertinent
34 documentation needed to evaluate the issue. CalOptima Health shall meet the internal target for
35 investigative closure within one hundred twenty (120) calendar days of receipt of the PQI, unless the

case needs to be expedited as needed for imminent member-safety risk or the case complexity, confidentiality limitations, external review needs, or related proceedings require additional time.

F. A case shall be considered:

1. Closed for investigation when a severity outcome score has been assigned;
2. Administratively closed when all required follow-up actions, including monitoring or corrective action verification, have been completed.

G. CalOptima Health's Chief Medical Officer (CMO) or Designee may refer PQI cases to the CalOptima Health CPRC for evaluation and action. Cases assigned Severity Outcome Score 3 shall be presented to CPRC. Other cases may be presented at the Medical Director's discretion.

H. CalOptima Health shall maintain confidentiality of QI case review information, in accordance with this policy and applicable privacy and confidentiality laws. When a case is designated confidential because a Member chooses anonymity, CalOptima Health shall limit disclosures and blind Member-identifying information in provider-facing communications to the extent practicable and permitted by law.

I. The QI Department shall track, trend, and analyze PQI data by issue, action, and severity level monthly to identify emerging patterns, inform quality improvement activities, and support referral of repeated or significant issues for further review. Analysis and findings shall be reported to CPRC.

J. When the outcome of a PQI review leads to corrective action, summary suspension or restriction, fair hearing rights, or external reporting obligations, CalOptima Health shall follow the applicable requirements in Policies GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues, GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network, GG.1616: Fair Hearing Plan for Licensates, and GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

K. CalOptima Health maintains a formal, written Quality Improvement Health Equity Transformation Program (QIHETP) approved by CalOptima Health's Quality Assurance Committee (QAC) of the Board and overseen through the CPRC and clinical leadership. The PQI process is a component of this governance structure.

L. CalOptima Health does not delegate PQI review and retains direct responsibility for performance of these activities.

III. PROCEDURE

A. Case Referral Intake

1. In addition to PQI referrals made by Providers and Health Networks, a PQI may be identified and referred to by CalOptima Health departments, committees and subcommittees, Grievance activity, monitoring activity, and other QOC-related activities.
2. Supporting documentation, including correspondence, Grievances, claims data, case management notes, shall accompany the referral whenever available. The referring party shall indicate whether the Member requests anonymity. CalOptima Health reserves the right to notify any appropriate governing, oversight, or regulatory body regarding concerns about any Provider delivering care to CalOptima Health Members.

3. Upon receipt of a PQI referral, a PQI case shall be opened by the QI Department. PQI cases shall be documented in CalOptima Health's care management system.
4. Cases identified as having imminent danger to the health of any individual shall be immediately referred to the CMO, their physician Designee, or CPRC to summarily suspend or restrict a contracted Provider's practice prerogatives if needed, in accordance with Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network.

B. Information Gathering, Provider Response, and Initial Review

1. The QI Nurse RN shall conduct an initial review of the PQI case and determine the additional information needed to conduct a full investigation.
2. The QI Department shall notify the Provider that a PQI has been opened, the issue related to the PQI and request pertinent medical records and, as applicable, a written response from the Provider(s) and/or Health Network involved rendering medical service(s) in the PQI. Requests shall specify the information sought, the requested submission date, the method of submission, and the CalOptima Health contact for procedural questions.
3. Unless otherwise specified due to urgency, confidentiality, or regulatory requirements, Providers and Health Networks shall be given a standard response timeframe established by department procedure, with extension requests considered for good cause. Failure to respond or submit requested information/documentation may result in review based on available information and may lead to further action, including a corrective action request, when appropriate.
4. The QI Department may collect and review surveys, incident reports, claims data, grievances, and other relevant internal or external information to assess QOC, QOS, and provider performance.
5. If Member anonymity limits the ability to obtain records or provider responses, the QI Department shall document those limitations and proceed using the information reasonably available.
6. The QI Department shall target investigative closure within one hundred and twenty (120) calendar days of PQI receipt. PQIs that are declined grievances shall receive preliminary Medical Director review within thirty (30) calendar days after the PQI is opened.

C. Nurse Review

1. The QI Nurse RN shall conduct a primary review of all PQI cases.
2. QI Nurses may close cases when:
 - a. The case is determined to be service-related only; and/or
 - b. No QOC or QOS issue is identified.
3. If a QI Nurse RN does not identify a QOC issue, a second QI Nurse RN shall review the case. If the second QI Nurse RN concurs, the case may be scored, and closed with the action of "No Further Action Required" and/or "Track and Trend."
4. If the QI Nurse identifies a QOC issue, the case shall be referred to a CalOptima Health Medical Director for review. The Medical Director shall assess service elements, including accessibility, availability, and continuity of care, and assess whether the provision and utilization of services meet professionally recognized standards of practice.

D. Medical Director Review and Severity Scoring

1. The Medical Director shall conduct a secondary review of all QOC cases. The Medical Director shall assign an outcome score that reflects the severity of the issue and determine whether further corrective action is warranted, in accordance with Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues.
2. CalOptima Health shall use the following outcome categories:

Outcome	Definition	Description
0	No Impact / No Risk: Care appears appropriate. No Quality-of-Care or Quality-of-Service issue identified.	- No provider error or lapse in clinical judgment. - Member received appropriate care without delay. - No documentation inaccuracies. - No follow-up action required beyond
1	Low Impact / Minimal Risk: Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member	- Slight deviation from best practice or documentation expectations. - Isolated, non-recurrent provider behavior. - No harm or care disruption. - Corrected at provider or supervisor level.
2	Moderate Impact / Moderate Risk: Moderate opportunity for improvement. Care deemed below standard or care, or potential for or actual moderate adverse outcome to member	- Moderate deviation from clinical guidelines or evidence-based practice. - Recurring provider documentation errors. - Member experienced a minor delay in care or care coordination. - Requires targeted provider feedback, re-training, or corrective action.
3	High Impact / Significant Risk: Significant opportunity for improvement. Care deemed below standard of care, or potential for or actual significant adverse outcome to Member.	- Major deviation from clinical practice guidelines or standards of care. - Member experienced care disruption or temporary adverse outcome. - Provider error impacted diagnostic accuracy or care timeliness. - Requires immediate escalation and further quality review
S0:	Service Only / Unverified: Service-related issue, unable to verify.	- No confirmable deviation in provider service or interaction. - Member dissatisfaction is noted, but objective evidence is absent. - No demonstrated impact on care, safety, or required services.
S1	Service Only Verified: Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.	- Service lapse confirmed (communication, respect, timeliness, professionalism). - No clinical impact or harm. - May affect member satisfaction or experience.

3. The Medical Director shall target a case investigative closure or case recommendation to CPRC within 30 days of the PQI case assignment. An additional 30 days is allotted if additional records or documentation is requested by the Medical Director.
4. The case may be closed for investigation by the CalOptima Health Medical Director or be referred and presented to CalOptima Health CPRC for further review and consideration(s).
 - a. Cases scored 0, S0, or S1, 1 and 2 may be closed by the Medical Director without CPRC review or they may be escalated to CPRC at the Medical Director's discretion.
 - b. Cases scored 3 will be presented to CPRC.

E. CPRC Review

1. PQI cases with a recommended outcomes score of 3 shall be presented to the CPRC by a Medical Director following completion of a comprehensive case review.
 - a. A comprehensive case review shall include an opportunity for the provider to provide a written clarification/response or a call with the Medical Director assigned the case to correct factual misunderstandings, submit context, describe corrective measures already taken and propose remediation.
 - b. The Provider shall be notified that the PQI has escalated to CPRC review and the notification shall include an offer for a written clarification/response or a call with the Medical Director assigned the case.
2. CPRC shall discuss presented cases and choose to adopt the recommended outcomes score or assign a different outcome score that reflects the severity of the issue. CPRC is chaired by the CMO or physician designee.
3. PQI cases assigned a severity score of 3 by CPRC shall trigger issuance of a letter to the Provider and, if appropriate, a letter shall be sent to the Provider's contracted Health Network(s) outlining the investigation's findings. CalOptima Health reserves the right to notify any appropriate governing, oversight, or regulatory body regarding concerns about any Provider delivering care to CalOptima Health Members.

F. External Review, Actions, and Provider Notification

1. CalOptima Health shall utilize an external review entity when a specific specialty is not represented by a CalOptima Health Medical Director or when a second opinion is needed.
2. A CalOptima Health CMO, Medical Director or CPRC may recommend and approve further corrective action if warranted, in accordance with Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues.
3. Once the PQI review process is completed, a PQI Provider resolution letter will be sent to the Provider or Health Network.
 - a. The PQI Provider resolution letter shall state the outcome at a level appropriate to the circumstances, identify required follow-up actions if any, and, for confidential cases, blind Member-identifying information.
4. Actions should be applied progressively when appropriate, taking into account patient safety risk, severity, repetition, provider responsiveness, and contractual or regulatory requirements.

5. The QI Nurse will implement the action(s) under the guidance of a CalOptima Health Medical Director and report back to a CalOptima Health Medical Director when the action is completed.
6. The QI Department shall document all PQI decisions, activity and actions in the Provider's PQI file in care management system, CalOptima Health's PQI system, and shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.
7. If the Provider or Health Network disagrees with the determination, the Provider or Health Network may contact the QI Department and/or pursue the applicable provider compliance process pursuant to CalOptima Health Policies CC.1202: CalOptima Health Provider Complaint, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.
8. If a Provider disagrees with the determination of an adverse action for Medical Disciplinary Cause or Reason requiring a reportable adverse action, the Provider shall be provided hearing rights, in accordance with Policy GG.1616 Fair Hearing Plan for Licentiates.

G. Provider Notification and Case Closure

1. Once the case is leveled with an outcomes score, the case is investigatively closed, and a letter will be sent to the Provider or Health Network notifying them that the investigation is closed.
2. Once all follow-up actions, including monitoring or corrective action verification, are completed, the case is administratively closed, and a letter will be sent to the Provider or Health Network notifying them that the PQI case is closed.

H. Trending and Reporting

1. The QI Department shall use statistical methods and quality improvement models to identify trends, patterns, and causes of PQIs issues and shall report to the CPRC, which includes the CMO, at least every six (6) months.
 - a. The QI Department may extract relevant information from case reviews, including those where no quality issues were identified, for trending, future study, and monitoring impact on health care quality, continuously assessing improvements, and to adjust strategies as needed.
 - b. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.
 - c. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary
 - d. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.
2. The QI Department shall follow up on all actions recommended by CPRC, track compliance, request evidence of implementation when required, and report status to CPRC until the action is complete.

3. Reporting Requirements

- a. Monthly: The QI Department shall report all PQI cases, closed the previous month, which includes identified adverse events. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.
- b. Quarterly: The QI Department shall submit a report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.
- c. Quarterly: The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC). Each quarter, the QIHEC shall submit summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP) Plan.
- d. At least semi-annually (every 6 months): QI reports to CPRC on all Practitioner-specific Member complaint cases referred to QI (QOC) by the GARS Department, including an evaluation of the history of complaints for all Practitioners.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. California Business and Professions Code, §805, 805.01, 809(b) and 1000
- B. California Health and Safety Code §1370
- C. CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP)
- D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
- F. CalOptima Health Contract with Covered California
- G. Covered California Physician Group Services Contract
- H. CalOptima Health Policy CC.1201: Member Grievance
- I. CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
- J. CalOptima Health Policy GG.1615: Practitioners and Organizational Providers Corrective Action Plan for Quality Issues
- K. CalOptima Health Policy GG.1616: Fair Hearing Process Plan for Licentiates
- L. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
- M. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
- N. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
- O. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
- P. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
- Q. CalOptima Health Policy HH.1102: Member Grievance
- R. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
- S. CalOptima Health Policy MA.9002: Enrollee Grievance Process
- T. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006) (Revised 08/31/2022)
- U. Peer Review Conclusion Letter
- V. Title 22, California Code of Regulations (C.C.R.), §51051

W. Title 28, California Code of Regulations (C.C.R.), §§1300.70(a)(1) and (3), 1300.70(b)(1)(B) and (C), 1300.70(b)(2)(C), 1300.70(c)
X. Title 42, Code of Federal Regulations (C.F.R), §422.152 and 438.330

REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use

BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/06/2026	Regular Meeting of the CalOptima Board of Directors

REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	02/01/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2023	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2025	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	05/01/2025	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised	08/01/2026	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised		GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare

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For October QAC Review Only

GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
805.01 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805.01 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public. 2. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely. 3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason, therefore. A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity – §805(a)(1)(B)(iv)
Agency	The relevant state licensing agency having regulatory jurisdiction over the Licentiates.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

Term	Definition
	<u>OneCare</u> : The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The CPRC is CalOptima Health's peer review body and makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all Practitioners and Organizational Providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee.
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.
Grievance	<u>Covered California</u>: 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. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Licentiate	"Licentiate" is defined in Section 809(b) of the California Business and Professions Code as a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, or dentist, and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

Term	Definition
	“Licentiate” is defined in Section 805 and 805.01 to include licensed midwives, physician assistants, and nurse practitioners for reporting.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	<u>Medi-Cal</u>: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, end-stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. <u>OneCare</u>: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of “Peer Review Body” in Business and Professions Code Section 805(a)(1)(b).
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member’s quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. <u>Medi-Cal</u>: 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. <u>OneCare</u>: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical

Term	Definition
	centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's Medical Director, or the Medical Director's Designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	<u>Medi-Cal</u>: Defined as, adequate access and availability to primary, behavioral health services, specialty health care, and long-term services and supports (LTSS) Providers and services; continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum. <u>OneCare</u>: Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Providers is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs.



Policy: GG.1615
Title: Practitioner and Organizational Provider Corrective Action Plan for Practitioners and Organizational Providers Quality Issues
Department: Quality Improvement Medical Management
Section: Not Applicable Quality Improvement
CEO Approval: /s/
Effective Date: 08/01/1998
Revised Date:
Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

~~This policy defines the appropriate Corrective Action process that CalOptima Health shall use Health's process for initiating and managing corrective actions for Practitioners and Organizational Providers (OPs), including routine monitoring, investigation, and Corrective Action (OP) when quality-related to their clinical practice concerns are identified. This policy ensures that issues affecting quality of care, patient safety, or performance are addressed in a timely, consistent, and transparent manner to support compliance and continuous improvement across the provider network.~~
The purpose of this policy is to establish CalOptima Health's process for initiating and managing corrective actions for Practitioners and Organizational Providers (OPs), including routine monitoring, investigation, and Corrective Action (OP) when quality-related to their clinical practice concerns are identified. This policy ensures that issues affecting quality of care, patient safety, or performance are addressed in a timely, consistent, and transparent manner to support compliance and continuous improvement across the provider network.

II. POLICY

~~A. The Quality Improvement Health Equity Committee (QHHEC) oversees CalOptima Health's Quality Improvement activities. CalOptima Health's Chief Executive Officer (CEO) and Chief Medical Officer (CMO) are responsible for the Quality of Care of services provided by CalOptima Health.~~

~~B. CalOptima Health's CMO or their physician Designee working through, as appropriate, such standing or ad hoc peer review committee as CalOptima Health may from time to time establish, shall design and implement an effective quality program for the following purposes:~~

- ~~1. To monitor and assess the quality of professional practice of all Practitioners, and Organizational Providers (OPs); and~~
- ~~2. To promote high quality of practice by providing education and counseling, issuing letters of admonition, warning or censure, as necessary; and requiring routine monitoring when deemed appropriate by CalOptima Health or the CalOptima Health Credentialing and Peer Review Committee (CPRC).~~

~~C. A.~~ CalOptima Health may conduct an investigation and initiate Corrective Action against an individual Practitioner or OP in any Health Network when necessary to ensure the safety of

CalOptima Health Members, or when the Practitioner or OP fails to meet applicable quality expectations and standards.

~~D. CalOptima Health shall take Corrective Action for either Non-Medical and Medical Disciplinary Cause or Reason, in accordance with the terms and conditions of this Policy.~~

~~E.B. Corrective Actions may be imposed based on administrative or clinical findings. Certain investigations and Corrective Actions (e.g., restriction of members or services) taken on the basis of a Medical Disciplinary Cause or Reason may be reportable under Section 805 and to the National Practitioner Data Bank (NPDB), in accordance with CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.~~

~~F. CalOptima Health shall implement any suspension or restriction imposed on a Practitioner for a Medical Disciplinary Cause or Reason in accordance with CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network.~~

~~G. CalOptima Health shall notify a Practitioner and OPs, in writing, in accordance with that Practitioner or OP's contract, but in no case less than ninety (90) calendar days prior to terminating the Practitioner's participation without cause, if appropriate.~~

~~H.C. Health Networks shall have policies and procedures consistent with this Policy that provide Practitioners and OPs with a Corrective Action process when the Health Network takes or proposes action including routine monitoring, Corrective Action, or investigation.~~

III. PROCEDURE

~~A. Routine Monitoring~~

~~1. All Practitioners and OPs, regardless of status, shall be subject to routine monitoring.~~

~~A. Initiation of Corrective Action~~

Corrective action(s) may be initiated when the

1. The Quality Improvement (QI) Department shall conduct regular patient reviews and studies of evaluations listed below identify a Practitioner or OP exhibiting performance concerns or practice consistent with CalOptima Health general quality assessment and improvement activities and shall investigate patterns that warrant remediation.

a. Quality of Care complaints and Potential Quality Issues (PQI) and complaints and Quality of Care incidents (PQIs) findings in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

b. Regulatory and/or routine audit findings.

a-c. Track and trend data to identify Practitioner and OP quality issues and/or patterns in clinical safety and shall report to the CPRC the results of investigations deemed a Quality of Care issue-quality of care

d. The QI Department shall routinely monitor, trend, Quality performance data.

e. Outcomes and analyze recommendations of the Credentialing and Peer Review Committee (CPRC) meetings.

~~b.f. Other Practitioner and OP PQI cases and Grievances/or OP quality-related information.~~

~~2. If any issues or trends emerge with any Practitioner or OP during the monitoring process and to assist them to conform their conduct or practice to the standards of CalOptima Health, the CMO or their physician Designee may issue informal comments or suggestions either orally or in writing or take Corrective Action as outlined in Section III.C. of this Policy.~~

~~3. Informal comments or suggestions shall be confidential and may be issued by the CMO or their physician Designee with or without prior discussion with the recipient and with or without consultation with any CalOptima Health committee.~~

~~a. Such comments or suggestions shall not constitute a restriction of practice prerogatives and shall not be considered to be a "Corrective Action" as that term is used in Section III.C.~~

~~B. Corrective Action for Medical Disciplinary or Non-Medical Disciplinary Cause or Reason~~

~~1. Criteria for Initiation~~

~~a. Any person may provide information to the CMO, QIHEC, CPRC or QI Department about the conduct, performance, or competence of any CalOptima Health Practitioner or OP.~~

~~4.2. A request for an investigation or a corrective action against a CalOptima Health Practitioner or OP may be initiated by the CalOptima Health Chief Medical Officer (CMO), the ~~CEO~~Deputy Chief Medical Officer (DCMO), a Medical Director, the Quality Improvement Health Equity Committee (QIHEC), the Credentialing Peer Review Committee (CPRC), or the Quality Improvement (QI) Department when upon completion of a review or investigation reliable information indicates that the Practitioner or OP has exhibited acts, demeanor, or conduct reasonably likely to be:~~

- ~~a. Detrimental to patient safety or to the delivery of quality patient care;~~
- ~~b. Unethical;~~
- ~~c. Discriminatory;~~
- ~~d. Contrary to CalOptima Health policies, rules, and regulations;~~
- ~~e. Contrary to their CalOptima Health agreement (if applicable); or,~~
- ~~f. Below applicable CalOptima Health standards.~~

~~2. Initiation~~

~~a. A request for an investigation must be submitted to the CalOptima Health Quality Improvement Department, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process and must be supported by reference to specific activities or conduct alleged to be detrimental to patient safety or to the delivery of quality patient care, unethical, contrary to CalOptima Health policies or the CalOptima Health contract (if applicable), or below CalOptima Health standards.~~

~~3. Investigation~~

- a. If the CalOptima Health CPRC concludes that an investigation is warranted, it shall direct an investigation to be undertaken in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.
- b. In the event of a formal investigation during the credentialing (or recredentialing) process and the Practitioner or OP withdraws their credentialing application, CalOptima Health shall determine if an 805 report and/or report to the NPDB is required, in accordance with CalOptima Health Policy GG.1657: State Licensing Board and National Practitioner Data Bank (NPDB) Reporting.

C.B. Corrective Action(s)

- ~~a. Corrective Action can be taken as a result of issues found through routine monitoring and subsequent PQI investigations in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process, or as a result of issues found during formal investigations.~~
- ~~b. Corrective Action may be for a non-medical/administrative reason or a Medical, Disciplinary Cause or Reason, and if, for a Medical Disciplinary Cause or reason may result in a reportable action.~~
- ~~c. At the conclusion(s) shall be implemented based on the severity of the investigation, the CPRC shall determine whether to recommend any Corrective Action, and if so, whether the Corrective Action recommended is for a non-medical or Medical Disciplinary Cause or Reason, and will determine if action is reportable pursuant to CalOptima Policy Health GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.~~
- ~~d. Corrective Action for a Non-Medical Disciplinary Cause or Reason identified quality issue(s) and~~
 1. ~~If a Corrective Action is recommended for a “non-medical disciplinary cause or reason” such as customer service related issues or delays in responding to medical records requests, the Corrective Action may include, without limitation, but are not limited to one or more of the following: interventions:~~
 - ~~a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant;~~
 - ~~a. Sending the Peer-to-Peer Discussions;~~
 - ~~a.b. Practitioner or OP a community best practice letter;~~
 - ~~b) Recommending Practitioner-Office staff education;~~
 - ~~b.c. Recommending office staff and/or training;~~
 - ~~d. Requesting Practitioner or OP assessment, education and/or training (i.e. UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or a Physician Enhancement Program (PEP);~~
 - ~~e. Monitoring through claims and utilization data, internal audits and/or MRR;~~
 - ~~f. Focused facility site review (FSR) or Medical Record Review (MRR);~~

e.g. Issuing a written Corrective Action Plan (CAP) with appropriate time frames for correction from the Practitioner demonstrating how the issue will be prevented in the future;

~~d.h. Issuing a letter~~Letter of warning, admonition, reprimand, or censure, ~~although nothing herein shall be deemed to preclude the CMO, or their physician Designee, the CPRC, or the QIHEC from issuing informal written or oral warnings outside of the mechanism for Corrective Action; or;~~

~~e.i. Taking other actions deemed appropriate under the circumstances, including, but not limited to, closing~~Closing physician panels or freezing specialist referrals;:

~~i. A Corrective Action for a “non-medical disciplinary cause or reason” shall not constitute a restriction of practice prerogatives, shall not be considered to be a reportable Corrective Action for a “Medical Disciplinary Cause or Reason” as that term is used in Section III.B.4.e. of this Policy, and shall not give rise to hearing rights as outlined in CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners.~~

j. Implementing probation;

k. Summary suspension and/or restriction on provision of services in accordance with CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health’s Network;

l. Denial or non-renewal of application for network participation;

m. Terminating participation in CalOptima Health’s network; and/or

n. Taking other actions deemed appropriate under the circumstances.

Corrective action(s) may be deferred

~~ii. If no improvement is found after the “non-medical disciplinary” Corrective Action is taken within the specified time frame and the issue addressed in the action is a contractual requirement, the CPRC may take action and/or escalate the case to CalOptima Health’s Office of Compliance for further action.~~

~~e. Corrective Action for a “Medical Disciplinary Cause or Reason”~~

~~i. If a Corrective Action is recommended for a “Medical Disciplinary Cause or Reason,” CPRC may recommend one or more of the following actions:~~

2. ~~Deferring action~~ for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant.

~~a) Sending the Practitioner or OP a best practice letter.~~

~~b) Recommending Practitioner education.~~

~~c) Recommending a written CAP from the Practitioner clearly demonstrating how the issue will be prevented in the future.~~

~~d) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or their physician Designee, the~~

CPRC, or the QIHEC from issuing informal written or oral warnings outside of the mechanism for Corrective Action.

f) ~~Recommending mandatory participation in: UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or a Physician Enhancement Program (PEP).~~

g) ~~Imposing, or the Practitioner's voluntarily acceptance of, a suspension of or restrictions on a Practitioner's provision of services to CalOptima Health Members.~~

3. Adverse Corrective Action for a "Medical Disciplinary Cause or Reason" generally triggering fair hearing rights in accordance with GG.1616 Fair Hearing Plan for Practitioners include:

a. Restriction for a cumulative total of thirty (30) calendar days or more in any twelve (12)-month period;

b. Impose a summary suspension if the summary suspension remains in effect for more than fourteen (14) calendar days.

c. Denial or non-renewal of application for network participation; and

a.d. Terminating participation in CalOptima Health's network.

4. Actions taken for a "Medical Disciplinary Cause or Reason" may require:

a. Initiate a fair hearing process for a Licentiate in accordance with GG.1616: Fair Hearing Process Plan of Licentiates.

a.b. Require reporting to the licensing Board under California Business and Professions Code Section 805 and/or 805.01 and/or reporting to the National Provider Data Bank (NPDB) pursuant to CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting. ~~Reporting under that policy may also be required upon resignation or a leave of absence by a Practitioner from participation in CalOptima Health programs after notice of an investigation initiated for a "Medical or Disciplinary Cause or Reason."~~

iv. ~~For an action that must be reportable under Section 805/805.01 hearing eligible, as described in CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network, include Medical Disciplinary Cause or Reasons such as:~~

a) ~~Incompetence;~~

b) ~~Gross deviation from the standard of care;~~

e) ~~Self-prescribing or self-administering controlled substances;~~

d) ~~Abusing drugs or alcohol;~~

e) ~~Repeated acts of excessive prescribing or providing controlled substances, and~~

f) ~~Sexual misconduct with a patient.~~

- 1
2 iv. ~~If the investigation concludes there is nothing of merit, no Corrective Action will be~~
3 ~~taken.~~

4
5 ~~D. Subsequent Actions~~

- 6
7 1. ~~If the CPRC recommends any reportable Corrective Action which would entitle a Practitioner to~~
8 ~~request a hearing, pursuant to CalOptima Health Policy GG.1616: Fair Hearing Plan for~~
9 ~~Practitioners, the CPRC shall give the Practitioner written notice of its recommendation, as~~
10 ~~provided in the CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners prior to~~
11 ~~imposing such action. A notification shall be sent to the QIHEC for informational purposes~~
12 ~~only. The CPRC shall also provide notice to CalOptima Health's Office of Compliance and to~~
13 ~~Legal Affairs. The written notice shall include:~~
14
15 a. ~~The reasons for the action;~~
16
17 b. ~~The standards and profiling data used to evaluate the Practitioner; and~~
18
19 e. ~~Information regarding the Practitioner's appeal rights.~~

20
21 ~~E. CPRC~~

- 22
23 ~~3.5. Any CPRC corrective action which has become effective shall remain in effect until it expires~~
24 ~~according to its own terms or is modified or terminated by the CPRC, a Judicial Review~~
25 ~~Committee, or the QIHEC.~~

26
27 C. Corrective Action Plan (CAP)

- 28
29 1. If a CAP is required to obtain a response along with a plan for Practitioner or OP's remediation
30 to address the quality issue, a QI Nurse in collaboration with the CMO, the Designee, or a
31 Medical Director shall communicate in writing to the Provider a detailed account of the quality
32 issue and/or findings and request a formal written CAP.
33
34 2. A response from the Practitioner or OP shall be received within thirty (30) calendar days of
35 receipt.
36
37 3. Proposed CAP shall include, at minimum, the following:
38
39 a. A description of the quality issue and/or finding
40
41 b. The root cause of the deficiency
42
43 c. Steps taken to resolve the deficiency
44
45 d. Steps taken to avoid reoccurrence
46
47 e. Responsible Party
48
49 f. Implementation Date
50
51 g. Evidence that corrective actions have been implemented
52

- 1 4. The CMO, the Designee, or a Medical Director shall review and approve (or deny) the
2 Practitioner or OP's proposed CAP to ensure full remediation of the sited deficiency, the
3 provider's understanding of the requirements, and efforts to proactively prevent reoccurrence.
4
5 5. The QI Nurse in collaboration with the CMO, the Designee, or a Medical Director shall provide
6 a written response to the Practitioner or OP, either accepting the CAP as provided or rejecting
7 the CAP with the request for additional information.
8
9 a. If a CAP is rejected, a written request describing additional information needed will be sent
10 to the Practitioner or OP and the Practitioner or OP will be provided with the opportunity to
11 resubmit the CAP.
12
13 ~~1. If the CPRC does not recommend any Corrective Action which would entitle the CalOptima~~
14 ~~Health Practitioner to a hearing, pursuant to CalOptima Health Policy GG.1616: Fair Hearing~~
15 ~~for Practitioners, the CPRC shall either file its report with a recommendation of no further~~
16 ~~action or take the action that is not reportable.~~
17
18 ~~2. If the CPRC action(s) is based on any of the following, instead of fifteen (15) calendar days~~
19 ~~after the effective date of decision, the Section 805/805.01 report must be filed within fifteen~~
20 ~~(15) calendar days of the final decision or recommendation of the CPRC, without regard to any~~
21 ~~subsequent hearing. These Medical Disciplinary Causes or Reasons covered by Section 805.01~~
22 ~~are:~~
23
24 a. ~~Incompetence;~~
25
26 b. ~~Gross deviation from the standard of care;~~
27
28 c. ~~Self prescribing or self administering controlled substances;~~
29
30 d. ~~Abusing drugs or alcohol;~~
31
32 e. ~~Repeated acts of excessive prescribing or providing of controlled substances; and~~
33
34 f. ~~Sexual misconduct with a patient.~~
35 6. the submitted CAP is rejected three times or if the Practitioner or OP fails to participate in the
36 CAP process, the Provider will be referred to CPRC for further evaluation and
37 recommendations.

38 ~~F.D.~~ Action Initiation by QIHEC

- 39
40
41 1. If the CPRC fails to investigate or take disciplinary action, contrary to the weight of the
42 evidence, the QIHEC may direct the CPRC to initiate an investigation or disciplinary action.
43
44 2. If the CPRC fails to take action in response to that direction from the QIHEC, the QIHEC may
45 initiate Corrective Action.
46

47 ~~G.E.~~ Automatic ~~Termination, Suspension or Limitation~~ and Immediate Adverse Action

- 48
49 1. A Practitioner or OP shall inform the CMO or delegate promptly, and in writing, of any change
50 in their compliance including, without limitation, professional license status, eligibility to
51 participate in any federal health care program, including Adverse action affecting a Practitioner
52 and/or OP participation in the CalOptima Health network, including restriction and termination.

may occur when as part ongoing monitoring, in accordance with Policy GG.1607: Monitoring Adverse Actions.

1. ~~Medi-Cal or Medicare, compliance with CalOptima Health requirements for professional liability insurance, or conviction of a felony.~~
2. ~~The Practitioner or OP also must inform the CMO pursuant to this Section, if they are listed in the OIG List of Excluded Individuals/Entities (LEIE), CMS Preclusion List, DHCS Restricted Provider Database, Drug Exclusion list, the System for Award Management (SAM) list, or the Medi-Cal Suspended and Ineligible Provider List.~~
3. ~~In the following instances, the Practitioner's or OP's participation may be terminated, suspended, limited, restricted, or placed on probation as described, and such action shall be final, without any of the procedural rights described in CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners. Further, any other action required by CalOptima Health policies and contractual requirements with respect to the Practitioner's participation in (including through the Health Networks) shall be taken as applicable.~~

a. ~~Licensure~~

- i. ~~Whenever a Practitioner's license or other legal credential authorizing practice in California is revoked, suspended, or has lapsed, the Practitioner's participation shall automatically be terminated as of the date such action becomes effective.~~
- ii. ~~Whenever a Practitioner's license or other legal credential authorizing practice in California is limited or restricted by the applicable licensing or certifying authority, the Practitioner's participation shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term, at least.~~
- iii. ~~Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, their participation status with CalOptima Health shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term, at least.~~
- iv. ~~Whenever a Practitioner's license or other legal credential is suspended, the Practitioner or OP's participation shall be suspended, at least for the term of the license or other legal credential suspension. CalOptima Health may, at the discretion of the CMO, terminate a Practitioner or OP when the terms of the Practitioner or OP's probation will impact patient care.~~

b. ~~Controlled Substances~~

- i. ~~Whenever a Practitioner's Drug Enforcement Administration (DEA) certificate is revoked, limited, or suspended, or has expired, the Practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and at least throughout its term.~~
- ii. ~~Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medication shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and at least throughout its term. CalOptima Health may, at the discretion of the CMO, terminate a Practitioner when the terms of the Practitioner's probation will impact patient care.~~

1 e.—Medicare/Medi-Cal

- 2
3 i.—If a Practitioner is suspended or excluded from participation or otherwise becomes
4 ineligible to participate in Federal or State health care programs including, without
5 limitation, the Medicare or Medi-Cal program, the Practitioner's participation shall
6 automatically be terminated as of the effective date of the sanction.
7

8 d.—Conviction of an Offense

- 9
10 i.—A Practitioner who is convicted of any offense (misdemeanor or felony) that is
11 substantially related to the qualifications, functions, or duties of a physician and
12 surgeons that constitute unprofessional conduct may be suspended or terminated at the
13 recommendation of the CMO or their designee. Such suspension or termination can be
14 effectuated upon conviction at the discretion of the CMO and does not await the
15 criminal conviction becoming final.
16
17 ii.—The CMO or their designee shall determine whether the conviction will warrant such
18 suspension or termination depending upon the circumstances of the offense and the
19 relationship between the offense for which the Practitioner is convicted and the
20 qualifications, functions or duties of the Practitioner.
21

22 e.—Professional Liability Insurance Eligibility

- 23
24 i.—If, for any reason, a Practitioner fails to maintain professional liability insurance as
25 required by CalOptima Health, the Practitioner's participation shall automatically be
26 suspended until the Practitioner is covered by professional liability insurance acceptable
27 to CalOptima Health.
28

29 IV. ATTACHMENT(S)

30 Not Applicable

31
32
33 V. REFERENCE(S)

34
35 A. California Business and Professions Code, Sections 805 & 805.01

36 B. Health and Safety Code, Division 2, Chapter 2.2, Article 5 Standards, Sections § 1300.67.2.2, §
37 1367.01 and § 1375.4

38 B.C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for
39 Medicare Advantage

40 C.D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal

41 D.E. CalOptima Health PACE Program Agreement

42 E.F. CalOptima Health Compliance Plan

43 F.G. CalOptima Health Quality Improvement Program

44 G.H. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process

45 H.I. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners/Licentiatees

46 I.J. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners

47 J.K. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers

48 K.L. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank
49 (NPDB) Reporting

50 L.M. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner
51 Participation in CalOptima Health's Network
52

1 VI. REGULATORY AGENCY APPROVAL(S)

2

Date	Regulatory Agency	Response
04/13/2021	Department of Health Care Services (DHCS)	Fulfilled Requirement
11/06/2025	Department of Health Care Services (DHCS)	File and Use

3 VII. BOARD ACTION(S)

4

5

Date	Meeting
03/04/2021	Regular Meeting of CalOptima Board of Directors

6 VIII. REVISION HISTORY

7

8

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/1998	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal
Revised	02/01/2003	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	07/01/2007	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	11/01/2011	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	03/01/2013	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare
Revised	03/04/2021	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2023	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2024	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
<u>Revised</u>		<u>GG.1615</u>	<u>Practitioner and Organizational Provider Corrective Action for Quality Issues</u>	<u>Medi-Cal</u> <u>OneCare</u> <u>PACE</u>

IX. GLOSSARY

Term	Definition
Corrective Action(s)	Specific identifiable activities or undertakings which address contract deficiencies, noncompliance, or regulatory deficiencies.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC).
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.
Grievance	<u>Covered California: 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.</u> <u>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.</u> <u>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</u>

Term	Definition
	care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. <u>PACE</u>: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested, 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), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Judicial Review Committee	An unbiased physician panel responsible for the review of fair hearing cases, deliberation and decision making.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	~~A beneficiary~~ <u>An individual</u> enrolled in a CalOptima Health program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Potential Quality Issue(s)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
<u>Provider</u>	<u>Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.</u> <u>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.</u>

Term	Definition
	<u>OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.</u>
Quality Improvement	Systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement Health Equity Committee	The CalOptima Health committee that is responsible for the Quality Improvement Health Equity (QIHEC) process.
Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Routine Monitoring	Review of a Practitioner or OP's practice and may include activities for which the Practitioner or OP's only obligation is to provide reasonable advance notice to any CalOptima Health committee or representative of certain patient care procedures or other patient care activity.
Suspension	Effective immediately, the Practitioner's panel will be closed and all CalOptima members will be redirected to another provider in good standing or new authorizations for the Practitioner or OP will cease and all open, unused authorizations will be modified, and members will be reauthorized to another specialist or OP in good standing.



Policy: GG.1615
Title: **Practitioner and Organizational
Provider Corrective Action for
Quality Issues**
Department: Quality Improvement
Section: Not Applicable

CEO Approval: /s/

Effective Date: 08/01/1998

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

The purpose of this policy is to establish CalOptima Health's process for initiating and managing corrective actions for Practitioners and Organizational Providers (OP) when quality-related concerns are identified. This policy ensures that issues affecting quality of care, patient safety, or performance are addressed in a timely, consistent, and transparent manner to support compliance and continuous improvement across the provider network.

II. POLICY

- A. CalOptima Health may conduct an investigation and initiate Corrective Action against an individual Practitioner or OP in any Health Network when necessary to ensure the safety of CalOptima Health Members, or when the Practitioner or OP fails to meet applicable quality expectations and standards.
- B. Corrective Actions may be imposed based on administrative or clinical findings. Certain investigations and Corrective Actions (e.g., restriction of members or services) taken on the basis of a Medical Disciplinary Cause or Reason may be reportable under Section 805 and to the National Practitioner Data Bank (NPDB), in accordance with CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.
- C. Health Networks shall have policies and procedures consistent with this Policy that provide Practitioners and OPs with a Corrective Action process when the Health Network takes or proposes action including routine monitoring, Corrective Action, or investigation.

III. PROCEDURE

A. Initiation of Corrective Action

1. Corrective action(s) may be initiated when the reviews and evaluations listed below identify a Practitioner or OP exhibiting performance concerns or practice patterns that warrant remediation.

- a. Quality of Care complaints and Potential Quality Issues (PQIs) findings in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.
 - b. Regulatory and/or routine audit findings.
 - c. Track and trend data to identify Practitioner and OP quality issues and/or patterns in clinical safety and quality of care
 - d. Quality performance data.
 - e. Outcomes and recommendations of the Credentialing and Peer Review Committee (CPRC) meetings.
 - f. Other Practitioner and/or OP quality-related information.
2. A request for an a corrective action against a CalOptima Health Practitioner or OP may be initiated by the CalOptima Health Chief Medical Officer (CMO), the Deputy Chief Medical Officer (DCMO), a Medical Director, the Quality Improvement Health Equity Committee (QIHEC), the Credentialing Peer Review Committee (CPRC), or the Quality Improvement (QI) Department when upon completion of a review or investigation reliable information indicates that the Practitioner or OP has exhibited acts, demeanor, or conduct reasonably likely to be:
- a. Detrimental to patient safety or to the delivery of quality patient care;
 - b. Unethical;
 - c. Discriminatory;
 - d. Contrary to CalOptima Health policies, rules, and regulations;
 - e. Contrary to their CalOptima Health agreement (if applicable); or
 - f. Below applicable CalOptima Health standards.
3. Investigation
- a. If the CalOptima Health CPRC concludes that an investigation is warranted, it shall direct an investigation to be undertaken in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.
 - b. In the event of a formal investigation during the credentialing (or recredentialing) process and the Practitioner or OP withdraws their credentialing application, CalOptima Health shall determine if an 805 report and/or report to the NPDB is required, in accordance with CalOptima Health Policy GG.1657: State Licensing Board and National Practitioner Data Bank (NPDB) Reporting.

B. Corrective Action(s)

1. Corrective Action(s) shall be implemented based on the severity of the identified quality issue(s) and may include but are not limited to one or more of the following interventions:
 - a. Peer-to-Peer Discussions;

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- b. Practitioner or OP a community best practice letter;
 - c. Office staff education and/or training;
 - d. Practitioner or OP assessment, education and/or training (i.e. UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or a Physician Enhancement Program (PEP);
 - e. Monitoring through claims and utilization data, internal audits and/or MRR;
 - f. Focused facility site review (FSR) or Medical Record Review (MRR);
 - g. Issuing a written Corrective Action Plan (CAP) with appropriate time frames for correction from the Practitioner demonstrating how the issue will be prevented in the future;
 - h. Letter of warning, admonition, reprimand, or censure;
 - i. Closing physician panels or freezing specialist referrals;
 - j. Implementing probation;
 - k. Summary suspension and/or restriction on provision of services in accordance with CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network;
 - l. Denial or non-renewal of application for network participation;
 - m. Terminating participation in CalOptima Health's network; and/or
 - n. Taking other actions deemed appropriate under the circumstances.
2. Corrective action(s) may be deferred for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant.
3. Adverse Corrective Action for a "Medical Disciplinary Cause or Reason" generally triggering fair hearing rights in accordance with GG.1616 Fair Hearing Plan for Practitioners include:
- a. Restriction for a cumulative total of thirty (30) calendar days or more in any twelve (12)-month period;
 - b. Impose a summary suspension if the summary suspension remains in effect for more than fourteen (14) calendar days.
 - c. Denial or non-renewal of application for network participation; and
 - d. Terminating participation in CalOptima Health's network.
4. Actions taken for a "Medical Disciplinary Cause or Reason" may:
- a. Initiate a fair hearing process for a Licentiate in accordance with GG.1616: Fair Hearing Process Plan of Licentiates.

b. Require reporting to the licensing Board under California Business and Professions Code Section 805 and/or 805.01 and/or reporting to the National Provider Data Bank (NPDB) pursuant to CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

5. Any corrective action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the CPRC, a Judicial Review Committee, or the QIHEC.

C. Corrective Action Plan (CAP)

1. If a CAP is required to obtain a response along with a plan for Practitioner or OP's remediation to address the quality issue, a QI Nurse in collaboration with the CMO, the Designee, or a Medical Director shall communicate in writing to the Provider a detailed account of the quality issue and/or findings and request a formal written CAP.

2. A response from the Practitioner or OP shall be received within thirty (30) calendar days of receipt.

3. Proposed CAP shall include, at minimum, the following:

a. A description of the quality issue and/or finding

b. The root cause of the deficiency

c. Steps taken to resolve the deficiency

d. Steps taken to avoid reoccurrence

e. Responsible Party

f. Implementation Date

g. Evidence that corrective actions have been implemented

4. The CMO, the Designee, or a Medical Director shall review and approve (or deny) the Practitioner or OP's proposed CAP to ensure full remediation of the sited deficiency, the provider's understanding of the requirements, and efforts to proactively prevent reoccurrence.

5. The QI Nurse in collaboration with the CMO, the Designee, or a Medical Director shall provide a written response to the Practitioner or OP, either accepting the CAP as provided or rejecting the CAP with the request for additional information.

a. If a CAP is rejected, a written request describing additional information needed will be sent to the Practitioner or OP and the Practitioner or OP will be provided with the opportunity to resubmit the CAP.

6. If the submitted CAP is rejected three times or if the Practitioner or OP fails to participate in the CAP process, the Provider will be referred to CPRC for further evaluation and recommendations.

D. Action Initiation by QIHEC

1. If the CPRC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the QIHEC may direct the CPRC to initiate an investigation or disciplinary action.
2. If the CPRC fails to take action in response to that direction from the QIHEC, the QIHEC may initiate Corrective Action.

E. Automatic and Immediate Adverse Action

1. Adverse action affecting a Practitioner and/or OP participation in the CalOptima Health network, including restriction and termination, may occur when as part ongoing monitoring, in accordance with Policy GG.1607: Monitoring Adverse Actions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. California Business and Professions Code, Sections 805 & 805.01
- B. Health and Safety Code, Division 2, Chapter 2.2, Article 5 Standards, Sections § 1300.67.2.2, § 1367.01 and § 1375.4
- C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
- D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- E. CalOptima Health PACE Program Agreement
- F. CalOptima Health Compliance Plan
- G. CalOptima Health Quality Improvement Program
- H. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
- I. CalOptima Health Policy GG.1616: Fair Hearing Plan for Licentiates
- J. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
- K. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
- L. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
- M. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/13/2021	Department of Health Care Services (DHCS)	Fulfilled Requirement
11/06/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/1998	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal
Revised	02/01/2003	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	07/01/2007	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	11/01/2011	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	03/01/2013	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare
Revised	03/04/2021	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2023	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2024	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised		GG.1615	Practitioner and Organizational Provider Corrective Action for Quality Issues	Medi-Cal OneCare PACE

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For October

1 IX. GLOSSARY
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Term	Definition
Corrective Action(s)	Specific identifiable activities or undertakings which address contract deficiencies, noncompliance, or regulatory deficiencies.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC).
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.
Grievance	<u>Covered California</u>: 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. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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

Term	Definition
	action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. <u>PACE</u>: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested, 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), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Judicial Review Committee	An unbiased physician panel responsible for the review of fair hearing cases, deliberation and decision making.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Potential Quality Issue(s)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. <u>Medi-Cal</u>: 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.

Term	Definition
	<u>OneCare</u> : Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement	Systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement Health Equity Committee	The CalOptima Health committee that is responsible for the Quality Improvement Health Equity (QIHEC) process.
Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Routine Monitoring	Review of a Practitioner or OP's practice and may include activities for which the Practitioner or OP's only obligation is to provide reasonable advance notice to any CalOptima Health committee or representative of certain patient care procedures or other patient care activity.
Suspension	Effective immediately, the Practitioner's panel will be closed and all CalOptima members will be redirected to another provider in good standing or new authorizations for the Practitioner or OP will cease and all open, unused authorizations will be modified, and members will be reauthorized to another specialist or OP in good standing.

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Policy: GG.1616
Title: **Fair Hearing Plan for
Practitioners/Licentiates**
Department: Quality Improvement
Section: Not Applicable

CEO Approval: /s/

Effective Date: 04/01/1996

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

~~This Policy defines the process that CalOptima Health shall use to provide a fair procedure to Practitioners when adverse actions are proposed to be taken or are taken by CalOptima Health and for which a report is required to be filed under California Business and Professions Code Section 805, or 805.01 and/or with the National Practitioner Data Bank (NPDB).~~

This policy establishes CalOptima Health's fair hearing process for Licentiates when a hearing right is triggered by a reportable or otherwise hearing-eligible adverse action as defined in Business and Professions Code Section 809(b). This policy governs notice of action, hearing request requirements, hearing scheduling, pre-hearing exchange, hearing procedures, Judicial Review Committee (JRC) decision-making, and final action following the hearing. Related processes, including corrective action, summary suspension or restriction, and reporting obligations, are governed by applicable CalOptima Health policies.

II. POLICY

~~A. The following CalOptima Health contracted practitioners are Licentiates as defined in Business and Professions Code Section 809(b) and shall offer Practitioners the procedural be given hearing rights set forth in this Policy.~~

~~B. A Peer Review investigation may be initiated and the opportunity to appeal certain hearing-eligible adverse decisions made by CalOptima Health whenever reliable information indicates a Practitioner may have engaged in actions that adversely affect, or could adversely affect, the health or welfare of a Member and may call into question Practitioner's competence or professional conduct.~~

~~A. If CalOptima Health's Credentialing and Peer Review Committee (CPRC) believes an adverse action is warranted, as a result of the Peer Review investigation, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process, CalOptima Health shall provide written notice to the Practitioner, which includes their rights to a hearing. Written notice shall be provided within thirty (30) calendar days of the committee's decision of the adverse recommendation-);~~

C. ~~A Practitioner may request a hearing within thirty (30) calendar days from the date of receipt of the written notice of CPRC's recommendation to file an 805 or 805.01 Report and/or with the NPDB for any of the below reasons:~~

- ~~1. Physicians and Surgeons;~~
- ~~2. Doctors of Podiatric Medicine;~~
- ~~3. Clinical Psychologists;~~
- ~~4. Marriage and Family Therapists;~~
- ~~5. Clinical Social Workers;~~
- ~~6. Professional Clinical Counselors;~~
- ~~7. Dentists; and~~
- ~~8. And persons authorized to practice under §§ 2113 or 2168.~~

B. Adverse actions for Medical Disciplinary Cause or Reason generally triggering fair hearing rights include:

~~1. CalOptima Health Initiated Actions:~~

- ~~1. Denial or non-renewal of a Practitioner's Licentiate's application for CalOptima Health network participation for a Medical Disciplinary Cause or Reason;~~

~~a. Non-renewal of a Practitioner's CalOptima Health participation for a Medical Disciplinary Cause or Reason;~~

~~2. Termination;~~

~~2.3. Restriction on a Practitioner's CalOptima Health participation for a cumulative total of thirty (30) calendar days or more in any twelve (12)-month period for a Medical Disciplinary Cause or Reason;~~

~~b. Termination of a Practitioner's CalOptima Health participation for a Medical Disciplinary Cause or Reason; or~~

~~3.4. Imposition of summary suspension of a Practitioner's CalOptima Health participation for a Medical Disciplinary Cause or Reason if the summary suspension remains in effect for more than fourteen (14) calendar days.~~

~~2. Practitioner Initiated Actions:~~

- ~~1. Resignation or leave of absence by a Practitioner from CalOptima Health participation after:~~

~~a. Notice of an investigation initiated for a Medical Disciplinary Cause or Reason; or~~

~~b. Notice that their application is denied or will be denied for a Medical Disciplinary Cause or Reason.~~

b. ~~Withdrawal or abandonment of a Practitioner's application for CalOptima Health participation after:~~

~~i. Notice of an investigation initiated for a Medical Disciplinary Cause or Reason; or~~

~~ii. Notice that their application is denied or will be denied for a Medical Disciplinary Cause or Reason.~~

e. ~~Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima Health participation after:~~

~~i. Notice of an investigation initiated for a Medical Disciplinary Cause or Reason; or~~

~~ii. Notice that their application is denied or will be denied for a Medical Disciplinary Cause or Reason.~~

~~3. Other Disciplinary Actions:~~

~~4.5.~~ Any other disciplinary action or recommendation that must be reported pursuant to California Business and Professions Code Section 805 or 805.01, and/or the NPDB.

C. Adverse actions not generally triggering fair hearing rights include educational letters, non-medical corrective action, written corrective action plans (CAPs) that do not independently qualify as reportable adverse action, and administrative actions that do not meet hearing thresholds.

D. CalOptima Health shall administer the fair hearing process in a manner that is timely, procedurally fair, and understandable to the affected Licentiate. Written notices issued under this policy shall include sufficient information for the Licentiate to understand the action being proposed or taken, the basis for that action, the applicable deadlines, and the process for requesting and participating in a hearing.

B.E. Except as otherwise provided in this Policy, no ~~Practitioner~~Licentiate shall be entitled, as a matter of right, to more than one (1) hearing on any matter.

~~D. With respect to the entirety of this process, technical, insignificant, or non-prejudicial deviations from the procedures set forth in this process shall not be grounds for invalidating the action taken.~~

C.F. If an adverse action as described in CalOptima Health Policy GG.1607: Monitoring Adverse Actions is identified, or an adverse action for a Medical Disciplinary Cause or Reason is recommended or taken pursuant to CalOptima Health Policy GG.1615: Practitioner and Organizational Provider Corrective Action Plan for Practitioners and Organizational Providers Quality Issues, a Practitioner Licentiate shall exhaust all remedies afforded by this Policy before resorting to legal action. If a Practitioner Licentiate fails to exhaust all remedies afforded by this Policy, CalOptima Health shall deem such Practitioner Licentiate to have waived all hearing and appeal requirements and to have accepted CalOptima Health's action or recommendation.

~~E. This Policy does not apply to the imposition of administrative restrictions, suspensions, or terminations resulting from the Practitioner's failure to meet specific credentialing and contractual obligations, including, without limitation, the failure to meet Minimum Provider Standards according to CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, or~~

~~where restrictions, suspensions, or terminations are not based on a Medical Disciplinary Cause or Reason.~~

~~D.G.~~ The hearing process described in this Policy may not be used to challenge any established law, rule, regulation, policy, or requirement. The Judicial Review Committee (JRC) has no authority to make findings or decisions to modify, limit, or overrule any established law, rule, regulation, policy, or requirement, and the JRC shall not entertain any such challenge.

~~E.H.~~ The JRC shall base its decision on all the evidence produced at the hearing, including all logical and reasonable inferences from the evidence as well as any written statements submitted to the JRC.

~~F.~~ Unless a summary suspension is imposed, if the Practitioner waives their procedural rights, then the recommendation of CalOptima Health shall be submitted for final action, as provided in Section III.A.20.f.

~~I.~~ The fair hearing rights described in this policy are distinct from any provider complaint, reconsideration, or routine dispute process described in other CalOptima Health policies. When an adverse action is hearing-eligible, this policy governs the Licentiate's formal hearing rights.

~~F.J.~~ Health Networks shall maintain policies and procedures consistent with this Policy that provide PractitionersLicentiate with formal appeal rights ~~when the Health Network takes or proposes adverse action for which an 805 or 805.01 Report and/or an NPDB report is required, as defined in Business and Professions Code Section 809(b).~~

III. PROCEDURE

~~A. Hearing Procedure~~

A. Notice of Action

1. If CalOptima Health takes or recommends ~~any of the final actions~~ an action described in Section II.D.4.B of this Policy, CalOptima Health shall provide written notice to the ~~PractitionerLicentiate~~ as soon as possible ~~after the CPRC takes or recommends the action (, but not later than thirty (30) calendar days thereafter);~~ after the action or recommendation by the CPRC, and such notice shall include the ~~Practitioner'sLicentiate's~~ right to a hearing.
2. The notice shall include:
 - ~~i. The action or recommendation against the Practitioner;~~
 - a. ~~CalOptima Health's obligation to report such action, if adopted, in accordance with Section 805 and 805.01 of the California Business and Professions Code and/or NPDB requirements;~~
 - b. A brief statement of the reasons for the action or recommendation;
 - c. The standards and criteria data used to evaluate the Licentiate;
 - d. CalOptima Health's obligation to report such action, if adopted~~The Practitioner's;~~

~~e.e.~~ The Licentiate's right to request a hearing within thirty (30) calendar days after the date of the notice; and

~~d.f.~~ A copy of this Policy.

B. Written Request for Hearing

~~1. A Practitioner may request a hearing by a JRC within The Licentiate shall have thirty (30) calendar days after the date of receipt of the notice described in Section III.A.1 of this Policy.~~

~~2.1. The Practitioner shall to submit a written request such for hearing in writing to the CalOptima Health Chief Medical Officer (CMO), or designee, as applicable.~~

~~3. If the Practitioner fails Failure to request a hearing within that period shall constitute waiver of the hearing in accordance with Sections III.A.2.a. and III.A.2.b of this Policy, CalOptima Health shall deem such Practitioner to:~~

~~i. Have waived the right to a hearing and to any appellate review for which they may have been eligible under this Policy; and~~

~~4.2. Have accepted CalOptima Health's action or final and the proposed action, which shall thereupon become effective immediately unless otherwise stated in the notice.~~

C. Scheduling of Hearing ~~Schedule~~

~~1. Upon timely receipt of a Practitioner's written request for a hearing, CalOptima Health shall deliver the request to the CPRC whose decision prompted schedule the hearing.~~

~~2. Except as set forth below, the hearing shall commence to begin not less than thirty (30) calendar days and not more than sixty (60) calendar days after the date the CMO receives the Practitioner's request for a hearing.~~

~~3.1. CalOptima Health may extend the time for commencement of the hearing, but in the event the request is received from a Practitioner who is under summary suspension, the hearing shall be held as soon as arrangements may be reasonably made, so long as the Practitioner has at least thirty (30) calendar days from the date of the notice to prepare for the hearing or provides written waiver of this right; unless:~~

~~a. CalOptima Health and the Practitioner may A shorter timeframe is required because a summary suspension remains in effect;~~

~~a.b. The parties agree, in writing, to delay the hearing; or~~

~~b.c. The hearing officer may issue a written decision to delay the hearing on a showing of grants a continuance for good cause.~~

D. Notice of Hearing ~~(charges)-with~~ Charges

1. If the ~~Practitioner makes a~~ Licentiate timely request ~~for~~ a hearing, CalOptima Health shall provide written notice of the hearing ~~to the Practitioner~~ at least thirty (30) calendar days ~~prior to the date of before~~ the hearing date.

2. ~~Such~~The notice shall include:

- a. The time, date, and location or method of ~~the hearing~~appearance;
 - b. The charge(s), reason(s) or basis for the ~~final~~ proposed action taken or recommended, including acts or omissions with which the ~~Practitioner~~Licentiate is charged and a list of the Members whose care is in question, where applicable; or, if the action involves denial of a ~~Practitioner's~~Licentiate's application for participation, the reason(s) for the denial; and
 - c. A summary of the ~~Practitioner's~~Licentiate's hearing rights and ~~the hearing~~ process.
3. CalOptima Health may amend the Notice of Hearing (~~with~~ charges) at any time so long as the ~~Practitioner~~Licentiate has a reasonable opportunity to prepare for and present a defense to the Notice of Hearing (with charges).

E. Judicial Review Committee (JRC)

1. Upon ~~receipt of~~receiving a request for a hearing, the CMO shall appoint a JRC, ~~at least a majority of whom shall hold the same professional license as Practitioner (e.g.,~~

a. ~~MD, RN, MFT, PsyD).~~ The CMO may designate a chairperson. The JRC shall be composed of ~~not less~~no fewer than three (3) members.

b. At least a majority of the members shall hold the same professional license as Licentiate (e.g., MD, RN, MFT, PsyD). ~~The JRC shall be composed of individuals who are not~~

c. Members must not be in direct economic competition with the ~~Practitioner, do~~Licentiate, must not have an apparent bias, ~~do~~must not stand to gain ~~any~~ direct financial benefit from the outcome of the hearing, and ~~shall~~must not have acted as accusers, investigators, fact finders, or initial decision makers ~~in at any prior stage of the matter to be decided at any previous level.~~ Knowledge of

a.d. Possession of knowledge about the underlying facts surrounding the charges does not preclude ~~disqualify~~ an individual from serving ~~as a member of~~on the JRC.

1.2. The CMO may designate a chairperson who shall ~~hear~~address all pre-hearing matters until the selection of a hearing officer is completed.

2.3. All members of the JRC ~~shall be present at~~are required to attend each hearing session, JRC meeting, and deliberation session unless CalOptima Health and ~~Practitioner~~Licentiate mutually agree that ~~any one (1) member need not attend~~ a particular member's necessary for a specific session or meeting.

3.4. ~~The decision~~Decisions of the JRC shall be determined by ~~a majority vote of the members.~~ The numerical vote shall be recorded.

4.5. ~~The~~All JRC members, including alternates and expert witnesses, shall ~~be paid~~receive a stipend for their service.

F. ~~Arbitrator~~

5.6. CalOptima Health may propose ~~that an arbitrator be selected in lieu of a JRC. The~~ use of an arbitrator ~~shall be subject to in lieu of convening a JRC. The appointment of an arbitrator requires the~~ mutual agreement ~~by of both~~ CalOptima Health and the ~~Practitioner~~ Licentiate. If an arbitrator is ~~used~~ selected, the ~~process described in Section III.A.6.b. of this Policy will~~ same rights, peer protections and written findings apply.

a. The arbitrator shall meet the same qualifications ~~as~~ required of a hearing officer and ~~will~~ shall be selected ~~using~~ through a process mutually acceptable to CalOptima Health and the ~~Practitioner~~ Licentiate. If the parties are unable to ~~agree~~ reach agreement, the arbitrator ~~will be selected pursuant to~~ shall be appointed in accordance with the Judicial Arbitration and Mediation Services (JAMS) Comprehensive Arbitration Rules & Procedures. If

a.b. ~~When~~ an arbitrator is ~~selected~~ utilized, no separate JRC or hearing officer shall be appointed, ~~and all. All~~ references ~~in within~~ this Policy to the ~~JRC or hearing officer~~ duties and responsibilities ~~of the JRC or hearing officer~~ shall be ~~read~~ interpreted as ~~applicable~~ applying to the arbitrator.

G.F. _____ Hearing Officer

1. The Chief Medical Officer (CMO) shall appoint a ~~hearing officer to preside at~~ qualified attorney as the hearing.

i. ~~The hearing officer shall be an attorney at law qualified to preside over a hearing and officer,~~ preferably ~~shall have~~ with experience in medical staff disciplinary matters.

ii. ~~The hearing officer shall:~~

a) ~~Not~~ must be ~~biased for or against the Practitioner;~~

b) ~~Gain~~ impartial, receive no direct financial benefit from the outcome; ~~and~~

1. ~~Not~~ shall not act as ~~a prosecuting officer or as~~ an advocate for any party.

2. The hearing officer shall ~~advise the Judicial Review Committee (JRC) and~~ participate in ~~the~~ deliberations ~~and act as a legal advisor to the JRC but shall not be entitled to vote.~~

3. The hearing officer shall ensure ~~that all participants in the hearing parties~~ have a ~~reasonable~~ fair opportunity to ~~be heard and to present all relevant oral and documentary evidence. The hearing officer and shall ensure proper~~ maintain decorum ~~is maintained at all times throughout the hearing.~~

4. The hearing officer ~~shall be entitled to determine~~ may set the order ~~of, or procedure and procedures~~ for, presenting evidence and argument ~~during the hearing.~~

5. The hearing officer ~~shall have~~ has the ~~authority and discretion, in accordance with this Policy,~~ to:

a. Grant continuances;

a. ~~Rule on challenges to JRC members;~~

b. ~~Rule on challenges to himself or herself serving as the hearing officer; to themselves;~~

- 1 c. ~~Rule on~~Decide questions ~~raised prior to, or during, the hearing pertaining to matters of law,~~
2 ~~procedures, or the procedure, and~~ admissibility of evidence;
3
4 d. ~~Exercise discretion in limiting the number of~~ Limit witnesses and ~~the overall amount of~~
5 evidence ~~introduced at the hearing as appropriate;~~
6
7 e. Impose ~~any~~ safeguards ~~for the protection of~~ to protect the hearing process ~~and, as justice~~
8 ~~requires, pursuant to~~ consistent with California Business and Professions Code Section
9 809.2;
10
11 f. ~~If requested by~~ Assist the JRC, ~~assist in the preparation of the JRC's upon request, in~~
12 ~~preparing its~~ report and recommendations; and
13
14 g. Take ~~such necessary~~ action ~~as may be warranted by the circumstances if the hearing officer~~
15 ~~determines that either side in a hearing party is not proceeding in an efficient and~~
16 ~~expeditious manner. efficiently.~~

- 17
18 6. ~~The hearing officer will be paid for their services pursuant to~~ shall be compensated under a
19 written agreement ~~between the hearing officer and with~~ CalOptima Health. ~~The terms of, and~~
20 the agreement terms shall be disclosed to the Licentiate.
21

22 G. Pre-hearing Procedures, Discovery and Evidentiary Exchange

23 1. Representation

- 24
25
26 a. If the Licentiate chooses to be accompanied by an attorney, they must provide written
27 notice as early as possible after CalOptima Health takes or recommends the action, and no
28 later than thirty (30) calendar days when submitting the hearing request.
29
30 b. CalOptima Health shall not be represented by an attorney if the Licentiate is not represented
31 by an attorney. This does not limit either party's ability to seek legal counsel for preparation
32 before the hearing.
33
34 c. If the Licentiate elects not to be represented by an attorney, they may instead be represented
35 by a licensed health care provider who is not an attorney.
36

37 2. Notification of Procedural Issues:

- 38
39 a. The Licentiate and the CPRC whose decision prompted the hearing shall exercise
40 reasonable diligence in notifying the hearing officer of any pending or anticipated
41 procedural issues as early as possible.
42
43 b. Any objections to pre-hearing decisions may be raised during the hearing, will be
44 preserved for appellate review, and shall be deemed waived if not raised at that time.
45

46 3. Discovery

- 47
48 a. Each party may inspect and copy, at their own expense, any relevant documents or
49 information relevant charges in the possession or control of the another party after making a
50 request.
51
52 b. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior
53 to the hearing constitutes good cause for a continuance.

c. At the request of either party, the hearing officer may deny a discovery if:

i. The information pertains solely to individually identifiable Licentiate other than the affected Licentiate;

ii. The denial is necessary to protect CPRC confidentiality; or

iii. The denial is justified in the interest of justice.

d. In resolving discovery disputes, the hearing officer may consider:

i. Whether the information could support or rebut charges;

ii. Whether the information is “exculpatory,” in that it would dispute or cast doubt upon the charges, or “inculpatory,” in that it would help support the charges or recommendation;

iii. The burden of production; and

iv. The number and scope of other discovery requests submitted.

4. Objections to Previously Unsubmitted Evidence

a. CalOptima Health may object to the introduction of evidence not provided during an credentialing application review or a peer review investigation despite CPRC requests.

b. The hearing officer shall exclude such information from the hearing unless the Licentiate demonstrates prior diligence and an inability to submit the information earlier.

5. Pre-hearing Exchange of Witness and Documents

a. At least ten (10) calendar days before the hearing, the parties shall exchange witness lists and copies of all documents they intend to introduce.

Failure to comply may result in a continuance, limitations on introducing untimely evidence or witnesses, and does not alter each party’s responsibility to make all relevant documents available for copying at least thirty (30) calendar days before the hearing.

H. Fair Hearing

1. Record of Hearing

a. A certified shorthand reporter shall record all hearing proceedings, and pre-hearing matters may also be recorded at the hearing officer’s discretion. CalOptima Health shall bear the cost of the reporter.

b. All parties may obtain a transcript or recording at their own reasonable expense, in which case both parties shall receive a copy.

2. Rights of Parties

1 a. At the hearing, both parties have the right to:

2
3 i. Question JRC members or the hearing officer regarding qualifications and raise
4 challenges consistent with this Policy;

5
6 ii. Call and examine witnesses;

7
8 iii. Present exhibits and relevant documents;

9
10 iv. Cross-examine and rebut evidence;

11
12 v. Submit a written closing statement; and

13
14 vi. Access all information provided to the JRC and to have a record made of the
15 proceedings.

16
17 b. The CPRC whose decision prompted the hearing, may examine the Licentiate as if under
18 cross-examination.

19
20 c. The hearing officer shall rule on any challenge to a JRC member or to themselves before
21 the hearing continues.

22
23 3. Admissibility of Evidence

24
25 a. Formal rules of evidence do not apply.

26
27 b. Relevant evidence—including hearsay—may be admitted if it is the type reasonably relied
28 upon in serious matters.

29
30 c. The JRC members may question witnesses and request that additional testimony as needed.

31
32 4. Burden of Going Forward and Burden of Proof

33
34 a. CalOptima Health shall first present evidence supporting the charge or recommended action
35 and need not prove every issue for its actions to be considered reasonable and warranted.

36
37 b. The Practitioner's initial applicant Licentiate shall bear the burden of proving, by a
38 preponderance of the evidence, that they possess the qualifications, experience, and
39 competency required for participation. They must provide sufficient information to resolve
40 reasonable doubts and may not introduce previously unsubmitted information unless they
41 demonstrate that it could not have been provided earlier with reasonable diligence.

42
43 a-c. For all other Licentiates, CalOptima Health bears the burden of proving by a preponderance
44 of the evidence that its action or recommendation is reasonable and warranted.

45
46 4.5. Failure to Appear

47
48 a. Practitioner's Licentiate's failure to appear and proceed at the hearing, absent good cause,
49 shall be deemed voluntary acceptance of the recommendation or action. In such cases, the
50 matter will be forwarded for final action as provided in Section III.A.20.f. following a vote
51 by the JRC to adopt the CalOptima Health recommendation.

52
53 H. Postponements and Extensions

- ~~1. Once a request for a hearing is initiated, postponements and extensions of time beyond the times permitted under this Policy may be allowed by the hearing officer upon a showing of good cause or upon agreement of the parties.~~
- ~~2. Extensions of time necessary to appoint a JRC, hearing officer, and/or arbitrator shall be deemed good cause, as long as both parties proceed in good faith.~~

~~I. Representation~~

- ~~1. The hearings provided for in this Policy are for the purpose of intra-professional resolution of matters related to professional conduct, professional competency, or character. Accordingly, the Practitioner is entitled to representation at the hearing as follows:~~
 - ~~a. If the Practitioner wishes to be accompanied at the hearing by an attorney, Practitioner shall provide written notice as soon as possible after CalOptima Health takes or recommends the action but not later than thirty (30) calendar days when requesting a hearing.~~
 - ~~b. CalOptima Health shall not be accompanied by an attorney if the Practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to assistance of legal counsel for the purpose of preparing for a hearing.~~
 - ~~c. If the Practitioner chooses not to be represented at the hearing by an attorney, they may be represented at the hearing by a licensed health care provider who is not also an attorney.~~

~~I. Pre-hearing Procedure~~

- ~~a. The Practitioner and the CPRC whose decision prompted the hearing shall exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularities as far in advance of the scheduled hearing as possible.~~
- ~~1. The Practitioner or CPRC whose decision prompted the hearing may raise objections to any pre-hearing decision at the hearing.~~
 - ~~a. Such objections shall be preserved for consideration at any appellate review hearing.~~
 - ~~b. If the Practitioner or CPRC whose decision prompted the hearing fails to raise any objections at the hearing, such objections shall be deemed to have been waived.~~

~~I. Discovery~~

- ~~a. The parties may inspect and copy, at their own expense, any documents or other information relevant to the charges in the possession of another party or under its control as soon as practicable after receipt of a request for the same.~~
- ~~1. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior to the hearing shall be good cause for a continuance of the hearing.~~
- ~~2. The hearing officer, at the request of CalOptima Health or Practitioner, may deny a discovery request if:~~

~~i. The information refers solely to individually identifiable Practitioners other than the affected Practitioner;~~

~~b. The denial is justified to protect the confidentiality of the CPRC process; or~~

~~iii. The denial is justified in the interest of justice.~~

~~3. In ruling on discovery disputes, the factors that may be considered include:~~

~~a. The information sought may be introduced to support or defend the charges;~~

~~b. The information is “exculpatory,” in that it would dispute or cast doubt upon the charges, or “inculpatory,” in that it would help support the charges or recommendation;~~

~~c. The burden on the party of producing the requested information; and~~

~~i. Other discovery requests made by the party;~~

~~K. Objections to the introduction of evidence previously not produced to CalOptima Health~~

~~1. CalOptima Health may object to the introduction of evidence that was not provided during an application review, or during a peer review investigation conducted pursuant to policy, despite the requests of the CPRC whose decision prompted the hearing for the information.~~

~~b. The hearing officer shall bar such information from the hearing unless the Practitioner is able to prove that they previously acted diligently and could not have submitted the information.~~

~~L. Pre-hearing Evidentiary Exchange~~

~~1. The parties shall exchange a list of witnesses expected to testify and copies of all documents that each party plans to introduce at the hearing.~~

~~2. The parties shall identify witnesses and exchange documents at least ten (10) calendar days prior to the hearing.~~

~~a. Failure to comply is good cause for the hearing officer to grant a continuance.~~

~~a. This provision shall not affect the initial responsibility of the parties to make all relevant documents available for copying at least thirty (30) calendar days prior to the commencement of the hearing.~~

~~b. Failure to comply shall be good cause for the hearing officer to limit introduction of any documents not provided, or witnesses not identified, by the other party in a timely manner.~~

~~2.1 Record of Hearing~~

~~3. A certified shorthand reporter shall be present to make a record of the hearing proceedings. The pre-hearing proceedings may be placed on the record if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by CalOptima Health.~~

2. The Practitioner or CPRC whose decision prompted the hearing shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. In such cases, both parties shall receive a copy of the transcript.

~~1. Rights of Parties~~

- a. At the hearing, both parties shall have the right to:
- i. Ask members of the JRC or the hearing officer questions directly related to determining if the members or the hearing officer meet the qualifications as set forth in Section III.A.5 and Section III.A.7 of this Policy and to challenge the members or the hearing officer;
 - ii. ~~Call and examine witnesses;~~
 - iii. Introduce exhibits and other relevant documents;
 - iv. Cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and otherwise rebut any evidence;
 - v. Provide a written statement at the close of the hearing; and
 - vi. Be provided with all information made available to the JRC and to have a record made of the proceedings.
- b. The CPRC whose decision prompted the hearing shall have the right to call and examine the Practitioner as if under cross-examination.
- c. The hearing officer shall rule on any challenge directed at a member of the JRC or the hearing officer prior to the continuation of the proceedings.

~~2.1 Admissibility of Evidence~~

- a. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence.
- b. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is the type of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.
- c. The JRC members may question the witnesses and may request that additional witnesses be called if they deem appropriate.

~~3.1 Burden of Going Forward and Burden of Proof~~

1. CalOptima Health shall have the initial duty to present evidence that supports the charge or recommended action. CalOptima Health is not required to prove each and every charge or issue before the JRC in order for its actions and/or recommendation(s) to be found reasonable and warranted.
2. An initial applicant Practitioner shall bear the burden of persuading the JRC by a preponderance of the evidence that they possess the requisite qualifications, experience, and competency to participate in CalOptima Health programs.

- 1
2 a.—An initial applicant Practitioner shall provide information that allows for adequate
3 evaluation and resolution of reasonable doubts concerning their current qualifications to
4 participate.
5
6 b.—An initial applicant Practitioner shall not introduce information not produced upon
7 CalOptima Health's request during the application process unless the applicant
8 Practitioner establishes that the information could not have been produced previously in
9 the exercise of reasonable diligence.
10
11 3.—Except as provided above for initial applicants, CalOptima Health shall bear the burden of
12 persuading the JRC, by a preponderance of the evidence, that its action or recommendation
13 is reasonable and warranted.
14

15 4.6. Adjournment and Conclusion

- 16
17 a. The hearing officer may adjourn and reconvene the hearing at the convenience of the
18 participants without special notice.
19
20 b. The hearing shall be concluded within a reasonable time, and the hearing officer may set
21 guidelines for the efficient introduction of evidence ~~to achieve a timely conclusion.~~
22
23 c. ~~The parties~~Parties may submit a written closing statement ~~at the conclusion of~~consistent
24 with the hearing. ~~The closing statement shall conform to the length, officer's established~~
25 ~~format, and submission guidelines outlined by the hearing officer, in consultation with the~~
26 ~~JRC deadlines.~~
27
28 d. ~~Upon conclusion of the presentation of oral and written~~After all evidence, arguments, and
29 closing statements have been presented, the hearing shall conclude. The JRC shall be
30 concluded. The JRC shall thereupon, then deliberate outside the presence of the parties;
31 ~~conduct its deliberations~~ and render its decision and accompanying written report.
32
33 e.d. Final adjournment shall not occur until occurs only after the JRC has completed completes
34 its deliberations.
35

36 M.I. _____ Decision of the JRC

- 37
38 1. ~~Within~~The JRC shall render its decision, accompanied by a written report, within thirty (6030)
39 calendar days after the conclusion of the evidentiary portion of the hearing, ~~the JRC shall render~~
40 ~~a decision accompanied by a written report that contains findings of fact and a conclusion~~
41 ~~articulating the connection between the evidence produced at the hearing and the decision.~~
42
43 2. If the ~~Practitioner~~Licentiate is under summary suspension, the ~~time for the~~ decision and report
44 shall be issued within fifteen (15) calendar days.
45
46 1.3. The ~~report shall be in~~written report shall include findings of fact and a clear explanation
47 connecting the evidence presented to the decision, with sufficient detail to enable allow the
48 parties and any appellate review body to determine understand the basis for the JRC's
49 decision determination on each ~~matter contained charge~~ in the Notice of Hearing (~~charges~~).
50
51 2.4. The JRC shall forward the decision ~~promptly but in not more to~~ CPRC, the CMO, and the
52 affected Licentiate promptly, and no later than thirty (30) calendar days from the date the

1 decision is rendered ~~to the CPRC whose decision prompted the hearing, the CMO, and the~~
2 ~~affected Practitioner.~~

3
4 ~~3.5.~~ The ~~JRC shall deliver the Practitioner's~~ Licentiate's copy of the decision and report shall be
5 delivered by registered or certified mail, return receipt requested, and by first-class mail.

6
7 ~~4.6.~~ The ~~JRC's~~ decision ~~of the JRC shall be considered~~ is final. There ~~shall be~~ is no right to appeal the
8 decision following the formal hearing.

9
10 ~~7.~~ The ~~JRC's~~ decision ~~of the JRC~~ shall be transmitted to the CMO. If the CMO and/or CPRC who
11 initiated the charges, in consultation with legal counsel, ~~is satisfied~~ determines that the ~~JRC's~~
12 decision ~~follows~~ resulting from ~~at the~~ fair hearing and is consistent with the applicable burden of
13 proof ~~as described above, it shall adopt that, the~~ decision shall be adopted as the final action of
14 CalOptima Health, and ~~the decision shall~~ be effective immediately.

15
16 ~~5.8.~~ If the CMO, in consultation with legal counsel, concludes that the JRC's decision does not
17 follow from a fair hearing ~~and/or~~ is inconsistent with the applicable burden of proof ~~as~~
18 ~~described above, then,~~ the CMO, ~~in consultation with legal counsel,~~ shall ~~proceed as it~~
19 ~~deem~~ take any action necessary ~~and appropriate~~ to address ~~any~~ the unfairness and render a
20 decision that is fair and consistent with this ~~policy~~ Policy.

21 ~~N.I.~~ Reporting

22
23
24 1. CalOptima Health shall comply with the reporting requirements of the California Business and
25 Professions Code and the NPDB in accordance with CalOptima Health ~~policies~~ Policy GG.1657:
26 State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

27
28 ~~b.~~ The CMO and/or CPRC shall file an 805 Report or 805.01 Report within fifteen (15)
29 calendar days and/or report to NPDB with thirty (30) calendar days of the following
30 actions:

31
32 ~~a.~~ CalOptima Health received confirmation that the Practitioner will not request a fair
33 hearing;

34
35 ~~b.~~ CalOptima Health did not receive a fair hearing request from the Practitioner, and thirty
36 (30) calendar days have passed from the date of receipt from the written notice; or

37
38 ~~c.~~ The CMO and/or CPRC adopts the JRC's decision to take any of the actions in
39 ~~H.D.1.a-e.~~

40 41 IV. ATTACHMENT(S)

42 Not Applicable

43 44 V. REFERENCE(S)

- 45
46
47 A. California Business and Professions Code, §§ 805, 805.01, and 809-~~2(b)~~
48 B. California Health and Safety Code, §1370
49 C. California Welfare and Institutions Code, §14000 et seq.
50 D. CalOptima Health Covered California Physician Group Services Contract
51 E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for
52 Medicare Advantage
53 F. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal

- G. CalOptima Health PACE Program Agreement
- H. CalOptima Health Contract with Covered California
- I. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
- J. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
- K. CalOptima Health Policy GG.1615: Practitioner and Organization Providers Corrective Action Plan for ~~Practitioners and Organizational Providers~~ Quality Issues
- ~~L. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards~~
- ~~M.L.~~ Fair Hearing Meeting Notice
- ~~N.M.~~ NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing
- ~~O.N.~~ Notice of Fair Hearing Rights
- ~~P.O.~~ Title 42, Code of Federal Regulations (C.F.R.), §§422.202, 422.204

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/10/2017	Department of Health Care Services (DHCS)	Approved as Submitted
12/06/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	03/01/1999	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2003	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	04/01/2007	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	11/01/2011	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2013	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Reviewed	06/01/2014	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal
Revised	06/01/2017	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	03/01/2020	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2022	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	11/01/2023	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2024	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1616	Fair Hearing Plan for Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2026	GG.1616	Fair Hearing Plan for Practitioners	Covered California Medi-Cal OneCare PACE
<u>Revised</u>		<u>GG.1616</u>	<u>Fair Hearing Plan for Licentiatees</u>	<u>Covered California</u> <u>Medi-Cal</u> <u>OneCare</u> <u>PACE</u>

For October QA

1 IX. GLOSSARY
2

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
805.01 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805.01 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public. 2. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely. 3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason, therefore. 4. A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity – §805(a)(1)(B)(iv)
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Judicial Review Committee (JRC)	The committee appointed to conduct a hearing based on a request for hearing by <u>Practitioner</u> ~~Licentiate~~ , as described in this Policy.
Medical Disciplinary Cause or Reason	Any aspect of a licentiate's competence or conduct that is reasonably likely to be detrimental to patient safety or care.

Member	An individual enrolled in a CalOptima Health program.
Minimum Provider Standards	The standards that must be met in order to submit an application for credentialing, the successful approval of which is a prerequisite to contracting with CalOptima Health or Health Networks in accordance with CalOptima Health Policy GG.1643: Minimum Provider Standards.
Term	Definition
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Practitioners to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Practitioner may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of “peer review body” in BPC § 805(a)(1)(B).
<u>Practitioner-Licentiate</u>	~~For the purposes of this Policy, “practitioner” shall have the same meaning as “Licentiate” as that term~~ is defined in Section 805 and 805.01809(b) of the California Business and Professions Code <u>and specifically as</u> a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, <u>or</u> dentist, ~~physician assistant~~ and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

1



Policy: GG.1616
Title: **Fair Hearing Plan for Licentiates**
Department: Quality Improvement
Section: Not Applicable

CEO Approval: /s/

Effective Date: 04/01/1996

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

This policy establishes CalOptima Health's fair hearing process for Licentiates when a hearing right is triggered by a reportable or otherwise hearing-eligible adverse action as defined in Business and Professions Code Section 809(b). This policy governs notice of action, hearing request requirements, hearing scheduling, pre-hearing exchange, hearing procedures, Judicial Review Committee (JRC) decision-making, and final action following the hearing. Related processes, including corrective action, summary suspension or restriction, and reporting obligations, are governed by applicable CalOptima Health policies.

II. POLICY

A. The following CalOptima Health contracted practitioners are Licentiates as defined in Business and Professions Code Section 809(b) and shall be given hearing rights and the opportunity to appeal certain hearing-eligible adverse decisions made by CalOptima Health's Credentialing and Peer Review Committee (CPRC):

1. Physicians and Surgeons;
2. Doctors of Podiatric Medicine;
3. Clinical Psychologists;
4. Marriage and Family Therapists;
5. Clinical Social Workers;
6. Professional Clinical Counselors;
7. Dentists; and
8. And persons authorized to practice under §§ 2113 or 2168.

B. Adverse actions for Medical Disciplinary Cause or Reason generally triggering fair hearing rights include:

1. Denial or non-renewal of a Licentiate's application for network participation;
 2. Termination;
 3. Restriction for a cumulative total of thirty (30) calendar days or more in any twelve (12)-month period;
 4. Imposition of summary suspension if the summary suspension remains in effect for more than fourteen (14) calendar days.
 5. Any other disciplinary action or recommendation that must be reported pursuant to California Business and Professions Code Section 805 or 805.01, and/or the NPDB.
- C. Adverse actions not generally triggering fair hearing rights include educational letters, non-medical corrective action, written corrective action plans (CAPs) that do not independently qualify as reportable adverse action, and administrative actions that do not meet hearing thresholds.
- D. CalOptima Health shall administer the fair hearing process in a manner that is timely, procedurally fair, and understandable to the affected Licentiate. Written notices issued under this policy shall include sufficient information for the Licentiate to understand the action being proposed or taken, the basis for that action, the applicable deadlines, and the process for requesting and participating in a hearing.
- E. Except as otherwise provided in this Policy, no Licentiate shall be entitled, as a matter of right, to more than one (1) hearing on any matter.
- F. If an adverse action as described in CalOptima Health Policy GG.1607: Monitoring Adverse Actions is identified, or an adverse action for a Medical Disciplinary Cause or Reason is recommended or taken pursuant to CalOptima Health Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues, a Licentiate shall exhaust all remedies afforded by this Policy before resorting to legal action. If a Licentiate fails to exhaust all remedies afforded by this Policy, CalOptima Health shall deem such Licentiate to have waived all hearing and appeal requirements and to have accepted CalOptima Health's action or recommendation.
- G. The hearing process described in this Policy may not be used to challenge any established law, rule, regulation, policy, or requirement. The Judicial Review Committee (JRC) has no authority to make findings or decisions to modify, limit, or overrule any established law, rule, regulation, policy, or requirement, and the JRC shall not entertain any such challenge.
- H. The JRC shall base its decision on all the evidence produced at the hearing, including all logical and reasonable inferences from the evidence as well as any written statements submitted to the JRC.
- I. The fair hearing rights described in this policy are distinct from any provider complaint, reconsideration, or routine dispute process described in other CalOptima Health policies. When an adverse action is hearing-eligible, this policy governs the Licentiate's formal hearing rights.
- J. Health Networks shall maintain policies and procedures consistent with this Policy that provide Licentiate with formal appeal rights as defined in Business and Professions Code Section 809(b).

III. PROCEDURE

A. Notice of Action

1. If CalOptima Health takes or recommends an action described in Section II. B of this Policy, CalOptima Health shall provide written notice to the Licentiate as soon as possible, but not later than thirty (30) calendar days after the action or recommendation by the CPRC, and such notice shall include the Licentiate's right to a hearing.
2. The notice shall include:
 - a. The action or recommendation;
 - b. A brief statement of the reasons for the action or recommendation;
 - c. The standards and criteria data used to evaluate the Licentiate;
 - d. CalOptima Health's obligation to report such action, if adopted;
 - e. The Licentiate's right to request a hearing within thirty (30) calendar days after the date of the notice; and
 - f. A copy of this Policy.

B. Written Request for Hearing

1. The Licentiate shall have thirty (30) calendar days after receipt of the notice to submit a written request for hearing to the CalOptima Health Chief Medical Officer (CMO), or designee.
2. Failure to request a hearing within that period shall constitute waiver of the hearing and any appellate review and the proposed action shall become effective immediately unless otherwise stated in the notice.

C. Scheduling of Hearing

1. Upon timely receipt of a written request, CalOptima Health shall schedule the hearing to begin not less than thirty (30) calendar days and not more than sixty (60) calendar days after the request is received, unless:
 - a. A shorter timeframe is required because a summary suspension remains in effect;
 - b. The parties agree in writing to delay the hearing; or
 - c. The hearing officer grants a continuance for good cause.

D. Notice of Hearing with Charges

1. If the Licentiate timely request a hearing, CalOptima Health shall provide written notice of the hearing at least thirty (30) calendar days before the hearing date.
2. The notice shall include:
 - a. The time, date, and location or method of appearance;

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- b. The charge(s), reason(s) or basis for the proposed action taken or recommended, including acts or omissions with which the Licentiate is charged and a list of the Members whose care is in question, where applicable; or, if the action involves denial of a Licentiate's application for participation, the reason(s) for the denial; and
 - c. A summary of the Licentiate's hearing rights and process.
3. CalOptima Health may amend the Notice of Hearing with charges at any time so long as the Licentiate has a reasonable opportunity to prepare for and present a defense to the Notice of Hearing with charges.
- E. Judicial Review Committee (JRC)
- 1. Upon receiving a request for a hearing, the CMO shall appoint a JRC.
 - a. The JRC shall be composed of no fewer than three (3) members.
 - b. At least a majority of the members shall hold the same professional license as Licentiate (e.g., MD, RN, MFT, PsyD).
 - c. Members must not be in direct economic competition with the Licentiate, must not have an apparent bias, must not stand to gain any direct financial benefit from the outcome of the hearing, and must not have acted as accusers, investigators, fact finders, or initial decision makers at any prior stage of the matter.
 - d. Possession of knowledge about the underlying facts surrounding the charges does not disqualify an individual from serving on the JRC.
 - 2. The CMO may designate a chairperson who shall address all pre-hearing matters until the selection of a hearing officer is completed.
 - 3. All members of the JRC are required to attend each hearing session, JRC meeting, and deliberation session unless CalOptima Health and Licentiate mutually agree that a particular member's necessary for a specific session or meeting.
 - 4. Decisions of the JRC shall be determined by majority vote. The numerical vote shall be recorded.
 - 5. All JRC members, including alternates and expert witnesses, shall receive a stipend for their service.
 - 6. CalOptima Health may propose the use of an arbitrator in lieu of convening a JRC. The appointment of an arbitrator requires the mutual agreement of both CalOptima Health and the Licentiate. If an arbitrator is selected, the same rights, peer protections and written findings apply.
 - a. The arbitrator shall meet the same qualifications required of a hearing officer and shall be selected through a process mutually acceptable to CalOptima Health and the Licentiate. If the parties are unable to reach agreement, the arbitrator shall be appointed in accordance with the Judicial Arbitration and Mediation Services (JAMS) Comprehensive Arbitration Rules & Procedures.

- 1 b. When an arbitrator is utilized, no separate JRC or hearing officer shall be appointed. All
2 references within this Policy to the duties and responsibilities of the JRC or hearing officer
3 shall be interpreted as applying to the arbitrator.
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5 F. Hearing Officer
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- 7 1. The Chief Medical Officer (CMO) shall appoint a qualified attorney as the hearing officer,
8 preferably with experience in medical staff disciplinary matters. The hearing officer
9 must be impartial, receive no direct financial benefit from the outcome, and shall not act as an
10 advocate for any party.
11
12 2. The hearing officer shall advise the Judicial Review Committee (JRC) and participate in
13 deliberations but shall not vote.
14
15 3. The hearing officer shall ensure all parties have a fair opportunity to present relevant evidence
16 and shall maintain decorum throughout the hearing.
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18 4. The hearing officer may set the order and procedures for presenting evidence and argument.
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20 5. The hearing officer has the discretion to:
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22 a. Grant continuances;
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24 b. Rule on challenges to JRC members or to themselves;
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26 c. Decide questions of law, procedure, and admissibility of evidence;
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28 d. Limit witnesses and evidence as appropriate;
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30 e. Impose safeguards to protect the hearing process consistent with California Business and
31 Professions Code Section 809.2;
32
33 f. Assist the JRC, upon request, in preparing its report and recommendations; and
34
35 g. Take necessary action if either party is not proceeding efficiently.
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37 6. The hearing officer shall be compensated under a written agreement with CalOptima Health,
38 and the agreement terms shall be disclosed to the Licentiate.
39

40 G. Pre-hearing Procedures, Discovery and Evidentiary Exchange
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42 1. Representation
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- 44 a. If the Licentiate chooses to be accompanied by an attorney, they must provide written
45 notice as early as possible after CalOptima Health takes or recommends the action, and no
46 later than thirty (30) calendar days when submitting the hearing request.
47
48 b. CalOptima Health shall not be represented by an attorney if the Licentiate is not represented
49 by an attorney. This does not limit either party's ability to seek legal counsel for preparation
50 before the hearing.
51
52 c. If the Licentiate elects not to be represented by an attorney, they may instead be represented
53 by a licensed health care provider who is not an attorney.

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2 2. Notification of Procedural Issues:
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4 a. The Licentiate and the CPRC whose decision prompted the hearing shall exercise
5 reasonable diligence in notifying the hearing officer of any pending or anticipated
6 procedural issues as early as possible.
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8 b. Any objections to pre-hearing decisions may be raised during the hearing, will be
9 preserved for appellate review, and shall be deemed waived if not raised at that time.
10

11 3. Discovery
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13 a. Each party may inspect and copy, at their own expense, any relevant documents or
14 information relevant charges in the possession or control of the another party after making a
15 request.
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17 b. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior
18 to the hearing constitutes good cause for a continuance.
19

20 c. At the request of either party, the hearing officer may deny a discovery if:
21

22 i. The information pertains solely to individually identifiable Licentiate other than the
23 affected Licentiate;
24

25 ii. The denial is necessary to protect CPRC confidentiality; or
26

27 iii. The denial is justified in the interest of justice.
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29 d. In resolving discovery disputes, the hearing officer may consider:
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31 i. Whether the information could support or rebut charges;
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33 ii. Whether the information is “exculpatory,” in that it would dispute or cast doubt upon
34 the charges, or “inculpatory,” in that it would help support the charges or
35 recommendation;
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37 iii. The burden of production; and
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39 iv. The number and scope of other discovery requests submitted.
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41 4. Objections to Previously Unsubmitted Evidence
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43 a. CalOptima Health may object to the introduction of evidence not provided during an
44 credentialing application review or a peer review investigation despite CPRC requests.
45

46 b. The hearing officer shall exclude such information from the hearing unless the Licentiate
47 demonstrates prior diligence and an inability to submit the information earlier.
48

49 5. Pre-hearing Exchange of Witness and Documents
50

51 a. At least ten (10) calendar days before the hearing, the parties shall exchange witness lists
52 and copies of all documents they intend to introduce.
53

1 Failure to comply may result in a continuance, limitations on introducing untimely evidence
2 or witnesses, and does not alter each party's responsibility to make all relevant documents
3 available for copying at least thirty (30) calendar days before the hearing.
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5 6 H. Fair Hearing

7 8 1. Record of Hearing

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10 a. A certified shorthand reporter shall record all hearing proceedings, and pre-hearing matters
11 may also be recorded at the hearing officer's discretion. CalOptima Health shall bear the
12 cost of the reporter.
13
14 b. All parties may obtain a transcript or recording at their own reasonable expense, in which
15 case both parties shall receive a copy.
16

17 18 2. Rights of Parties

- 19 a. At the hearing, both parties have the right to:
20
21 i. Question JRC members or the hearing officer regarding qualifications and raise
22 challenges consistent with this Policy;
23
24 ii. Call and examine witnesses;
25
26 iii. Present exhibits and relevant documents;
27
28 iv. Cross-examine and rebut evidence;
29
30 v. Submit a written closing statement; and
31
32 vi. Access all information provided to the JRC and to have a record made of the
33 proceedings.
34
35 b. The CPRC whose decision prompted the hearing, may examine the Licentiate as if under
36 cross-examination.
37
38 c. The hearing officer shall rule on any challenge to a JRC member or to themselves before
39 the hearing continues.
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41 42 3. Admissibility of Evidence

- 43 a. Formal rules of evidence do not apply.
44
45 b. Relevant evidence—including hearsay—may be admitted if it is the type reasonably relied
46 upon in serious matters.
47
48 c. The JRC members may question witnesses and request that additional testimony as needed.
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50 51 4. Burden of Going Forward and Burden of Proof

- 52 a. CalOptima Health shall first present evidence supporting the charge or recommended action
53 and need not prove every issue for its actions to be considered reasonable and warranted.

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- b. The initial applicant Licentiate shall bear the burden of proving, by a preponderance of the evidence, that they possess the qualifications, experience, and competency required for participation. They must provide sufficient information to resolve reasonable doubts and may not introduce previously unsubmitted information unless they demonstrate that it could not have been provided earlier with reasonable diligence.
 - c. For all other Licentiates, CalOptima Health bears the burden of proving by a preponderance of the evidence that its action or recommendation is reasonable and warranted.
5. Failure to Appear
- a. Licentiate's failure to appear and proceed at the hearing, absent good cause, shall be deemed voluntary acceptance of the recommendation or action. In such cases, the matter will be forwarded for final action following a vote by the JRC to adopt the CalOptima Health recommendation.
6. Adjournment and Conclusion
- a. The hearing officer may adjourn and reconvene the hearing at the convenience of the participants without special notice.
 - b. The hearing shall be concluded within a reasonable time, and the hearing officer may set guidelines for the efficient introduction of evidence.
 - c. Parties may submit a written closing statement consistent with the hearing officer's established format and deadlines.
 - d. After all evidence, arguments, and closing statements have been presented, the hearing shall conclude. The JRC shall then deliberate outside the presence of the parties and render its decision and written report. Final adjournment occurs only after the JRC completes its deliberations.
- I. Decision of the JRC
- 1. The JRC shall render its decision, accompanied by a written report, within thirty (30) calendar days after the conclusion of the evidentiary portion of the hearing.
 - 2. If the Licentiate is under summary suspension, the decision and report shall be issued within fifteen (15) calendar days.
 - 3. The written report shall include findings of fact and a clear explanation connecting the evidence presented to the decision, with sufficient detail to allow the parties and any appellate review body to understand the basis for the JRC's determination on each charge in the Notice of Hearing.
 - 4. The JRC shall forward the decision to CPRC, the CMO, and the affected Licentiate promptly, and no later than thirty (30) calendar days from the date the decision is rendered.
 - 5. The Licentiate's copy of the decision and report shall be delivered by registered or certified mail, return receipt requested, and by first-class mail.

6. The JRC's decision is final. There is no right to appeal the decision following the formal hearing.
7. The JRC's decision shall be transmitted to the CMO. If the CMO and/or CPRC who initiated the charges, in consultation with legal counsel, determines that the decision resulting from the fair hearing and is consistent with the applicable burden of proof, the decision shall be adopted as the final action of CalOptima Health, and be effective immediately.
8. If the CMO, in consultation with legal counsel, concludes that the JRC's decision does not follow from a fair hearing or is inconsistent with the applicable burden of proof, the CMO shall take any action necessary to address the unfairness and render a decision that is fair and consistent with this Policy.

J. Reporting

1. CalOptima Health shall comply with the reporting requirements of the California Business and Professions Code and the NPDB in accordance with CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. California Business and Professions Code, §§ 805, 805.01, and 809(b)
- B. California Health and Safety Code, §1370
- C. California Welfare and Institutions Code, §14000 et seq.
- D. CalOptima Health Covered California Physician Group Services Contract
- E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
- F. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
- G. CalOptima Health PACE Program Agreement
- H. CalOptima Health Contract with Covered California
- I. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
- J. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
- K. CalOptima Health Policy GG.1615: Practitioner and Organization Providers Corrective Action Plan for Quality Issues
- L. Fair Hearing Meeting Notice
- M. NCOA Health Plan Standards and Guidelines: Credentialing and Recredentialing
- N. Notice of Fair Hearing Rights
- O. Title 42, Code of Federal Regulations (C.F.R.), §§422.202, 422.204

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/10/2017	Department of Health Care Services (DHCS)	Approved as Submitted
12/06/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	03/01/1999	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2003	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	04/01/2007	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	11/01/2011	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2013	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Reviewed	06/01/2014	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal
Revised	06/01/2017	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	03/01/2020	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/01/2022	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	11/01/2023	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2024	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1616	Fair Hearing Plan for Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2026	GG.1616	Fair Hearing Plan for Practitioners	Covered California Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised		GG.1616	Fair Hearing Plan for Licentiates	Covered California Medi-Cal OneCare PACE

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For October QAC Review Only

1 IX. GLOSSARY
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Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
805.01 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805.01 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public. 2. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely. 3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason, therefore. 4. A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity – §805(a)(1)(B)(iv)
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Judicial Review Committee (JRC)	The committee appointed to conduct a hearing based on a request for hearing by Licentiate, as described in this Policy.
Medical Disciplinary Cause or Reason	Any aspect of a licentiate's competence or conduct that is reasonably likely to be detrimental to patient safety or care.

Term	Definition
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Practitioners to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Practitioner may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of “peer review body” in BPC § 805(a)(1)(B).
Licentiate	“Licentiate” is defined in Section 809(b) of the California Business and Professions Code as a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, or dentist, and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.



Policy: GG.1650
Title: **Credentialing and Recredentialing of Practitioners**
Department: Quality Improvement
Section: Not Applicable

CEO Approval: /s/

Effective Date: 06/01/2017

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether 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 its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following 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 Delegate's ability to perform these activities, including an initial review to ensure that the 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 the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.~~

~~C.B.~~ CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. Delegates shall perform functions that, at minimum, meet the requirements as outlined in this policy.
2. CalOptima Health may accept evidence of ~~NCQA~~National Committee for Quality Assurance (NCQA) Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

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

~~E.D.~~ CalOptima Health's CMO or Designee, or CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health, consistent with Department of Health Care Services (DHCS, National Committee for Quality Assurance (NCQA), and Department of Managed Health Care (DMHC), and Centers for Medicare & Medicaid (CMS) regulations and standards. The initial Credentialing decision is valid for a period of three (3) years.

~~F.E.~~ CalOptima Health and its Delegates shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/~~Re-credentialing~~Recredentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway-, such as California Department of Public Health (CDPH).
2. CalOptima Health may enroll ~~providers~~practitioners through the screening and enrollment process outlined in Section III.G, in compliance with DHCS requirements, or CalOptima Health may direct network ~~providers~~practitioners 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 in Medi-Cal but must comply with CalOptima Health's vetting process.

~~G.F.~~ CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network 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' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates 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 and its Delegates 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~~reinitiate 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 the termination.

H.G. CalOptima Health and its Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members 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 25 United States Code (USC) § 1621t.
 - b. CalOptima Health and its Delegates 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 Care and Specialty Care services);
3. In an independent relationship with CalOptima Health;
 - a. An independent relationship exists when ~~the~~ CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and
4. Providing care to Members under CalOptima Health's programs.

H.H. CalOptima Health and its Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;
2. Locum Tenens;
 - ~~a. CalOptima Health shall provisionally credential the practitioner if the locum tenens works less than sixty (60) calendar days.~~
 - ~~b. CalOptima Health shall fully credential the practitioner if the locum tenens works sixty (60) calendar days or more.~~
3. Facilities;
4. Telemedicine/telehealth (i.e., virtual care visit); or
5. Rental and preferred provider organization networks.

~~H.I.~~ CalOptima Health and its Delegates shall credential and recredential the following practitioners including, but not limited to:

1. Medical Doctor (MD);
2. Doctor of Osteopathy (DO);
3. Doctor of Chiropractic Medicine (DC);
4. Doctor of Dental Surgery (DDS);
5. Doctor of Podiatric Medicine (DPM);
6. Nurse Practitioners (NP); and
7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant), Midwife, Physical Therapist, etc.
 - a. Behavioral health practitioners, including but not limited to:
 - i. Psychiatrists and other physicians;
 - ii. Addiction medicine specialists;
 - iii. Doctoral or master's level psychologists;
 - iv. Master's-level clinical social workers;
 - v. Master's-level clinical nurse specialists or psychiatric nurse practitioners; and
 - vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors, qualified autism services (QAS) providers also known as applied behavior analysis ~~providers~~) (ABA) practitioners).

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

1. Credentialed and recredentialed NMPs include:
 - a. 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;
 - i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104;
 - b. 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 licensing board, between the NMP and the Organized Health Care System; or

c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

2. 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 NMP's employment with the entity or Organized Health System.

~~L.K.~~ For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, 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. No history of Fraud, Waste, and/or ~~abuse~~ Abuse;
4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; ~~and, which is completed by the contracted organization and validated through an attestation;~~

~~5. No~~ Review of history of liability claims against the practitioner; ~~and~~

~~5-6. Review of federal and state exclusion, sanction, and debarment sources.~~

M. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (e.g., hospitalists), intensivists, pathologists, etc. and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting.
2. Practitioners who 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 functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy MA.5012: Pharmacy Network Credentialing and Access).
4. Covering practitioners 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.
7. Students, residents, and fellows, where applicable.

- 1 8. Rental network practitioners who provide out-of-area care only, and Members
2 are not required or given an incentive to seek care from them.
3
- 4 9. Health care professionals who are permitted to furnish services as part of a letter of agreement
5 (LOA) or a continuity of care arrangement.
6
- 7 N. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified
8 Health Centers (FQHCs) and FQHC Look-Alikes and does not credential or recredential medical
9 practitioners who practice exclusively within a FQHC or FQHC Look-Alikes and who provide care
10 for a Member only as a result of the Member being directed to the FQHC or FQHC Look-Alikes.
11
- 12 O. CalOptima Health and its Delegates shall recredential a practitioner at least every three (3) years,
13 utilizing a thirty-six (36) month cycle to the month, not to the day.
14
- 15 P. CalOptima Health and its Delegates shall ensure that all practitioners maintain current California
16 licensure, as applicable, and shall monitor various state and federal boards, agencies, and databanks
17 for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse
18 Actions.
19
- 20 Q. CalOptima Health and its Delegates shall notify the practitioner, in writing, of the Credentialing or
21 Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the
22 application.
23
- 24 R. CalOptima Health and its Delegates shall not discriminate against any practitioner during the
25 Credentialing and Recredentialing process.
26
- 27 1. CalOptima Health and its Delegates shall not discriminate, in terms of participation,
28 reimbursement, or indemnification, against any practitioner who is acting within the scope of their
29 license, certification, or registration under federal and state law, solely on the basis of the license,
30 or certification. This prohibition shall not preclude CalOptima Health from:
31
- 32 a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the
33 needs of Members;
34
- 35 b. Using different reimbursement amounts for different specialties, or for different practitioners
36 in the same specialty; and
37
- 38 c. Implementing measures designed to maintain quality and control costs consistent with
39 CalOptima Health's responsibilities.
40
- 41 2. CalOptima Health and its Delegates shall not discriminate against a practitioner that serves high-
42 risk populations or specializes in the treatment of costly conditions.
43
- 44 3. CalOptima Health and its Delegates shall not base Credentialing and Recredentialing decisions on
45 a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of
46 procedure, or patient's insurance coverage, in which the practitioner specializes.
47
- 48 S. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing and
49 Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of
50 Provider Credentialing Information.
51

- 1 T. CalOptima Health and its Delegates shall ensure that information collected on the application is no
2 more than six (6) months old from the date of the final decision made by the ~~respective Credentialing~~
3 ~~committee~~ CMO or its designee or CPRC.
4
5 1. CalOptima Health and its Delegates shall notify the Covered California practitioner within ten
6 (10) business days from receipt of an application and completion of primary source verification to
7 verify receipt and inform the applicant whether the application is complete.
8
9 2. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare, or PACE practitioner
10 within thirty (30) calendar days from receipt of an application and completion of primary source
11 verification to verify receipt and inform the applicant whether the application is complete.
12
13 3. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the
14 application shall be considered expired, and Credentialing will ~~re-initialize~~ be discontinued.
15
16 U. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima
17 Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR)
18 processes to a Health Network. CalOptima Health assumes all authority, responsibility, and
19 coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its
20 findings to Health Networks to incorporate the documents to support review prior to Credentialing
21 decisions.
22

23 III. PROCEDURE

24 A. Practitioner Initial Credentialing

- 25 1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.
26
27 a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or its
28 Delegate shall send a notification electronically, explaining the expectations for completion
29 and submission of the Credentialing application and required documents.
30
31 b. CalOptima Health and its Delegates shall utilize the most recent versions of DataSpring (also
32 referred to as the Council for Affordable Quality Health Care (CAQH)) credentialing form
33 and processes for Credentialing and Recredentialing. CalOptima Health and/or its Delegates
34 shall only request additional information from an applicant practitioner to clarify and confirm
35 information that is provided on the CAQH credentialing form, including verification of
36 information not specifically disclosed on the practitioner's application.
37
38 c. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health
39 Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will
40 verify that the Physician Practitioner meets the minimum standards as provided in that policy.
41
42 d. Practitioners shall submit a current, signed, and dated application with attestation to
43 CalOptima Health.
44
45 e. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner
46 and make a credentialing decision within one hundred eighty days (180) of the signed
47 attestation date.
48
49 f. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral
50 Health ~~Provider~~ Practitioner in the Covered California provider network within sixty (60) days
51
52

after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

- i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health ~~Provider~~Practitioner whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.
- g. 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 DHCS APL 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.
- h. Practitioners shall attest to:
 - i. Any work history gap that ~~exceeds~~exceed six (6) months ~~and~~must include 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.
- i. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).
- j. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.
- k. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.
- l. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.
- m. If the required information is not received within sixty (60) 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.

- 1 n. An NMP, other than a PA, who does not have an independent relationship with CalOptima
2 Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed
3 supervisory agreement or delegation of services agreement indicating the name of supervising
4 Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health;
5 stating the NMP agrees to follow protocols developed for practice by the supervising
6 Physician Practitioner based on skills and area of specialty or provide a copy of the
7 employment agreement with the credentialed practitioner.
8
9 o. A PA who does not have an independent relationship with CalOptima Health or a Delegate
10 and is supervised by Physician Practitioner or has an agreement with an Organized Health
11 Care System, must include:
12
13 i. A delegation of services agreement indicating name of supervising Physician Practitioner
14 who is practicing, licensed, and credentialed by CalOptima Health; statement that the
15 NMP agrees to follow protocols developed for practice by the supervising physician
16 based on skills and area of specialty or provide a copy of the employment agreement with
17 the credentialed Physician Practitioner; or
18
19 ii. A signed Practice Agreement between the NMP and the Organized Health Care System
20 stating that the PA agrees to follow protocols developed for practice by the Organized
21 Health Care System based on skills and area of specialty or provide a copy of the Practice
22 Agreement with the credentialed Organized Health Care System.
23
24 2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO
25 shall verify the information provided through primary source or a contracted agent of the primary
26 source using NCQA-accepted and/or industry-recognized verification sources. This information
27 includes, but is not limited to:
28
29 a. A current, valid California license to practice in effect at the time of the Credentialing
30 decision (verification time limit: 120 calendar days);
31
32 b. Board Certification, as applicable, unless exempt from the Board Certification requirement
33 pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for
34 Physicians (verification time limit: 120 calendar days);
35
36 c. Education and training, including evidence of graduation from an appropriate professional
37 school, continuing education requirements, and if applicable, completion of residency and
38 specialty training;
39
40 d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care
41 practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health
42 Policy GG.1608: Full Scope Site Reviews;
43
44 e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as
45 required; and
46
47 f. ~~Medicare program enrollment opt-out status (i.e. Is not currently on the opt-out Medicare Opt~~
48 ~~Out list).~~
49
50 3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from
51 each practitioner, as applicable, but need not verify this information through a primary source (see
52 Attachment A). This information includes, but is not limited to:

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- a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);
 - b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), 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/or 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. This requirement is not applicable for ~~practitioner~~practitioners who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written description of their process for handling instances when a patient requires a controlled substance.
 - d. 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 (verification time limit: 120 calendar days);
 - 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 (verification time limit: 120 calendar days).
 - e. ~~Practitioner information entered in the National Practitioner~~National Practitioner Data Bank (NPDB), ~~including malpractice history;~~ Continuous Query (CQ) (verification time limit: 120 calendar days) if applicable;
 - f. No current 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 42 USC § 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.
- g. ~~No history~~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;
- h. ~~No history~~History of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include ~~accusations~~, probation, a previously filed 805 and ~~or~~ 805.1 report with a licensing board; and
- i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.
4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:
- a. For ~~doulas and comply~~Doulas, compliance with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.
- b. For Community Health Workers (CHW) ~~and comply~~, compliance with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.
5. CalOptima Health, a Delegate, or CVO shall have appropriate documentation in the credentialing files using either of the following methods or a combination:
- a. Credentialing documents signed (or initialed) and dated by the verifier
- b. A checklist that includes, for each verification:
- i. The source used;
- ii. The date of verification;
- iii. The signature or initials of the person who verified the information;
- iv. Typed initials are only accepted if there is a unique electronic signature or identifier on the checklist; and
- v. The report date, if applicable.
- c. A checklist with a single signature and a date for all verifications that includes a statement confirming that the signatory verified all credentials on that date and that includes for each verification:
- i. The source used; and
- ii. The report date, if applicable.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after ~~initial~~ Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO 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.A. 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. 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 twenty (120) 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. Member satisfaction, if applicable; and
 - v. Compliance with the terms of the practitioner's contract.
 - c. All Recredentialing applications must include the attestations as contained in the practitioner's ~~initial~~ Credentialing 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 or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing ~~review~~.
4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.
 - a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.
 - b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to Policy GG.1607 Monitoring Adverse Actions.
5. CalOptima Health, a Delegate, or CVO shall have appropriate documentation in the credentialing files using either of the following methods or a combination:
 - a. Credentialing documents signed (or initialed) and dated by the verifier; and

b. A checklist that includes, for each verification:

i. The source used;

ii. The date of verification;

iii. The signature or initials of the person who verified the information; and

iv. Typed initials are only accepted if there is a unique electronic signature or identifier on the checklist

v. The report date, if applicable

c. A checklist with a single signature and a date for all verifications that includes a statement confirming that the signatory verified all credentials on that date and that includes for each verification:

i. The source used; and

ii. The report date, if applicable.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), exclusion, sanction and debarment sources, etc., but does not extend to review of information, references, or recommendations protected by law from disclosure (i.e., peer-review protected information).

b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing or Recredentialing information obtained from ~~other~~ sources during Credentialing or Recredentialing varies from that provided by the practitioner in the Credentialing or Recredentialing application;

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 email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

- c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

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

Email: mycredentialingupdates@caloptima.org

Email: mycredentialingupdates@caloptima.org

- d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.
- iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing or Recredentialing verification requirements, or if federal or state law prohibits disclosure.
- iv. Documentation of receipt of corrections:
- a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing or Recredentialing file.
- b) A practitioner shall be notified via fax, email, or certified letter to document receipt of the identified erroneous information.
- v. Right to be notified of application status
- a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon written request.
- b) Practitioners can contact the QI Department by ~~phone or e-mail~~ email requesting the status of their application. The QI Department will aim to respond within seven (7) business day of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding credentialing and recredentialing.
2. CalOptima Health shall designate the ~~Credentialing and Peer Review Committee (CPRC)~~ CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.
3. 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.

- 1 4. Completed Credentialing and Recredentialing files will either be presented to the CMO or
2 Designee on a clean file list for signature or will be presented at CPRC for review and approval.
3
- 4 a. A clean file consists of a complete application with a signed attestation and consent form,
5 supporting documents, and verification of no more than one (1) professional review or
6 malpractice claim(s) that resulted in settlements or judgments greater than twenty-five
7 thousand dollars (\$25,000) paid by, or on behalf of, the practitioner within the last seven (7)
8 years from the date of the Credentialing or Recredentialing review.
9
- 10 i. A clean file shall be considered approved and effective on the date that the CMO or
11 Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file;
12 ~~and deems the file clean.~~
13
- 14 ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for
15 ~~final approval and to~~ be reflected in the meeting minutes.
16
- 17 b. Files that do not meet the clean file review process and that require further review by CPRC
18 include, but are not limited to, those files that include more than one (1) malpractice claim
19 that resulted in a settlement or judgment greater than twenty-five thousand dollars (\$25,000),
20 or NPDB ~~queryCQ~~ identifying ~~medical board~~ investigations, or other actions.
21
- 22 i. ~~Non-Files that do not meet~~ clean ~~list files~~file criteria will be reviewed by CPRC for
23 determination to accept, or deny, the application.
24
- 25 ii. CPRC shall give thoughtful consideration to the information presented in the
26 Credentialing ~~or Recredentialing~~ file, which ~~consideration~~ shall be reflected in the
27 minutes of the CPRC meeting.
28
- 29 iii. CPRC meetings and decisions may take place in ~~real time~~person, or as a virtual meeting
30 via telephone or video conference but may not be conducted ~~through e-mail~~via email.
31
- 32 5. Practitioner files identified as not meeting Credentialing ~~or Recredentialing~~ criteria with
33 exceptions or potential exceptions, which may include serious quality deficiencies that result in
34 the suspension or termination of a practitioner, shall be referred to the CMO or ~~designee~~Designee
35 for review.
36
- 37 a. The CMO or Designee shall review each ~~practitioner~~ file ~~for practitioners who do~~who does
38 not meet Credentialing ~~or Recredentialing~~ criteria and make recommendations regarding
39 ~~approving~~approval or ~~denying~~denial of Credentialing ~~or Recredentialing~~ of the practitioner to
40 the CPRC. For practitioner files ~~which do~~ not ~~meeting~~meet criteria on an administrative basis
41 only, ~~(e.g., does not meet standard requirements to be considered for Credentialing or~~
42 ~~Recredentialing)~~ the file may be approved or denied by the CMO or Designee.
43
- 44 6. The CPRC shall make a final determination based on the ~~practitioners'~~practitioner's ability to
45 deliver care based on the Credentialing ~~or Recredentialing~~ information collected from the file
46 review process ~~and that~~which is verified prior to ~~making a~~the Credentialing ~~or Recredentialing~~
47 decision.
48
- 49 a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar
50 days of the decision indicating:
51
- 52 i. Acceptance;

1
2 ii. Acceptance for less than three (3) years;

3
4 iii. Acceptance with specific conditions, which shall not be defined as restrictions and are not
5 reportable to the NPDB and/or under 805 or 805.1 requirements;

6
7 ~~ii.~~iv. Acceptance with restrictions along with appeal rights information, in accordance with
8 CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

9
10 ~~iii.~~v. Denial of the application along with appeal rights information, in accordance with
11 CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of
12 explanation forwarded to the applicant.

13
14 b. CalOptima Health and its Delegates shall make a determination regarding the credentials of a
15 Covered California practitioner within ninety (90) days after receiving a completed
16 practitioner credentialing application, including all required third-party verifications.
17 CalOptima Health and its Delegates shall notify a practitioner, if successfully approved, of
18 the activation within ten (10) business days of approval if the approval occurs prior to the end
19 of the ninety (90)-day timeline. The ninety (90)-day timeline shall apply only to the
20 credentialing process and does not include contracting completion. If CalOptima Health and
21 its Delegates do not meet the ninety (90)-day requirement, the practitioner's credentials shall
22 be provisionally approved for one hundred twenty (120) days unless any of the following
23 apply:

24
25 i. The practitioner is subject to discipline by the licensing entity for the practitioner.

26
27 ii. The practitioner has one or more adverse action reports or one or more reports of
28 malpractice payments filed with the National Practitioner Data Bank (NPDB).

29
30 iii. The practitioner has not been credentialed by CalOptima Health or its Delegates in the
31 past five (5) years.

32
33 c. CalOptima Health shall render a final Credentialing or Recredentialing decision for Medi-Cal,
34 OneCare and PACE practitioners within one hundred twenty (120) calendar days from the
35 date of a completed application, which includes a signed attestation that confirms the
36 correctness and completeness of the application.

37
38 i. Application attestations must be signed within ~~the~~ one hundred eighty (180) calendar
39 days prior to the Credentialing or Recredentialing decision. If the practitioner's
40 attestation expires prior to the Credentialing decision, the practitioner must reattest that
41 the information on the application remains correct and complete, by resigning and
42 redating the attestation.

43
44 ii. As of January 1, 2027, CalOptima Health and its Delegates shall notify the practitioner
45 within ten (10) business days to verify receipt and inform the applicant whether the
46 application is complete, which includes collection of the application and third-party
47 verifications.

48
49 7. If CalOptima Health terminates a practitioner during the Recredentialing process for
50 administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information)
51 and not for quality reasons (*i.e.*, medical disciplinary cause or reason), CalOptima Health may
52 reinstate the practitioner within thirty (30) calendar days of termination and is not required to re-

perform ~~initial~~ Credentialing. However, CalOptima Health must ~~re-verify~~reverify credentials that are no longer within the verification time limit. If the reinstatement ~~would be~~is more than thirty (30) calendar days after termination, CalOptima Health must perform ~~initial~~ Credentialing of such practitioner.

- a. Termination ~~of privileges~~ includes failure or refusal to renew a contract or to renew, extend, or reestablish ~~any staff privilegessuch~~, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and its Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

- a. 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.Q.;
- 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 CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.
- b. QI Department staff shall remove identifying information, such as name, gender, National Provider Identifier (NPI) and group affiliation, from ~~the~~ practitioner ~~and provider~~ files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the ~~credentialing~~Credentialing or Recredentialing profile with ~~the~~ Contracting, Provider Relations, and Provider Data Management Service (PDMS) ~~Departments~~departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing or Recredentialing process (*i.e.*, education, training, ~~Board Certification~~board certification, and specialty). ~~The~~ PDMS ~~Department~~ will enter the contract and elements of Credentialing or Recredentialing data into CalOptima Health's core business system(s) and/or will verify the Credentialing data in ~~the system, which~~such systems, as needed, and updates pertinent information ~~into the~~for propagation to the printed and/or online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

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

- 1 2.—If a practitioner is not already enrolled with DHCS as a Medi-Cal Fee For Service (FFS)
2 practitioner, ~~then the practitioner screening and enrollment process does not need to be completed~~
3 ~~by~~ CalOptima Health.
- 4
- 5 3.—If a practitioner is not already enrolled with DHCS as a Medi-Cal FFS practitioner, then
6 CalOptima Health may does not complete screening and enrollment established by CalOptima
7 Health.
- 8
- 9 a.—CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to
10 implementation. The P&Ps must define the scope of their enrollment process if CalOptima
11 Health does not enroll all provider types.
- 12
- 13 b.—CalOptima Health shall complete the process and provide the applicant with a written
14 determination on CalOptima Health letterhead within one hundred twenty (120) calendar days
15 of its receipt of a practitioner application.
- 16
- 17 c.—CalOptima Health shall submit a list of its newly enrolled practitioners every six months to
18 CalOptima Health's DHCS Managed Care Operations Division (MCO) contract manager.
- 19
- 20 d.—CalOptima Health shall collect all the appropriate information, data elements, and supporting
21 documentation required for each provider type and ensure that the application is reviewed for
22 both accuracy and completeness.
- 23
- 24 i.—CalOptima Health shall inform practitioners seeking to enroll with CalOptima Health of
25 the differences between CalOptima Health's and DHCS's provider enrollment processes,
26 including the practitioner's right to enroll through DHCS, at the time of application.
27 CalOptima Health will provide required disclosures that include, but are not limited to,
28 the following elements:
- 29
- 30 a)—A statement that certain enrollment functions will not be performed by CalOptima
31 Health but will continue to be performed by DHCS, including fingerprinting, criminal
32 background checks, and decisions to deny or terminate enrollment.
- 33
- 34 b)—A notice that some of the enrollment requirements and rights found in the state
35 enrollment process may not be applicable when a practitioner If CalOptima Health
36 chooses to enroll through CalOptima Health, including provisional practitioner status
37 with Medi-Cal FFS, processing timelines of the enrollment application, and the
38 ability to appeal CalOptima Health's decision to suspend the enrollment process.
- 39
- 40 c)—A provision informing the practitioner that if CalOptima Health receives any
41 information that impacts the practitioner's eligibility for enrollment, CalOptima
42 Health will suspend processing of the practitioner's enrollment application and make
43 the practitioner aware of the option to apply through DHCS' Medi-Cal FFS
44 practitioner enrollment process.
- 45
- 46 d)—A statement clarifying that in order for the practitioner to participate in the Medi-Cal
47 FFS program, the practitioner must enroll through DHCS, and that enrolling through
48 DHCS will also make the practitioner eligible to contract with CalOptima Health.
- 49
- 50 ii.—CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS
51 enrollment application fee amount.
- 52

- 1 iii. ~~CalOptima Health shall obtain the practitioner's consent in order to share information~~
2 ~~relating to the practitioner's application and eligibility with DHCS.~~
- 3
- 4 iv. ~~CalOptima Health shall collect and maintain the original signed Medi-Cal Provider~~
5 ~~Agreement and Network Provider Agreement for each practitioner.~~
- 6
- 7 v. ~~CalOptima Health shall maintain all practitioner enrollment documentation in a secure~~
8 ~~manner to ensure confidentiality of the practitioner's personal information.~~
- 9
- 10 vi. ~~Enrollment records shall be made available upon request to DHCS, CMS or other~~
11 ~~authorized governmental agencies.~~
- 12
- 13 e. ~~Practitioners that apply as a partnership, corporation, governmental entity, or nonprofit~~
14 ~~organization must disclose ownership or control information as required by 42 CFR §~~
15 ~~455.104.~~
- 16
- 17 i. ~~Practitioners who are unincorporated sole proprietors are not required to disclose the~~
18 ~~ownership or control information.~~
- 19
- 20 ii. ~~Upon CalOptima Health's request, a practitioner must submit within thirty five (35)~~
21 ~~calendar days:~~
- 22
- 23 a) ~~Full and complete information about the ownership of any subcontractor with whom~~
24 ~~the practitioner has had business transactions totaling more than twenty five thousand~~
25 ~~dollars (\$25,000) during the twelve (12) month period ending on the date of the~~
26 ~~request; and~~
- 27
- 28 b) ~~Any significant business transactions between the practitioner and any wholly owned~~
29 ~~supplier, or between the practitioner and any subcontractor, during the five (5) year~~
30 ~~period ending on the date of the request.~~
- 31
- 32 f. ~~CalOptima Health shall screen initial practitioner applications, including applications for a~~
33 ~~new practice location, and any applications received in response to a practitioner's~~
34 ~~reenrollment or revalidation request to determine the practitioner's categorical risk level as~~
35 ~~limited, moderate, or high.~~
- 36
- 37 1. ~~If a practitioner fits within more than one risk level, CalOptima Health must screen the~~
38 ~~practitioner at the highest risk level.~~
- 39
- 40 2. ~~A practitioner's designated risk level is also affected by findings of license verification,~~
41 ~~site reviews, checks of suspended and terminated practitioner lists, and criminal~~
42 ~~background checks.~~
- 43
- 44 3. ~~CalOptima Health shall not enroll a practitioner who fails to comply with the screening~~
45 ~~criteria for that practitioner's assigned level of risk.~~
- 46
- 47 g. ~~Practitioners are subject to screening based on verification of the following requirements:~~
- 48
- 49 1. ~~Limited Risk Practitioners:~~
- 50
- 51 a) ~~Meet state and federal requirements;~~
- 52

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

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

2. ~~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 CalOptima Health and DHCS is accurate and to determine compliance with state and federal enrollment requirements.~~

3. ~~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:~~

~~complete DHCS screening and enrollment.~~

1. ~~The state imposes a payment suspension on a practitioner based on a credible allegation(s) of Fraud, Waste, or abuse.~~

2. ~~The practitioner has an existing Medicaid overpayment based on Fraud, Waste, or abuse.~~

3. ~~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.~~

4. ~~The practitioner would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six (6) months.~~

i. ~~Additional criteria for high risk practitioners~~

3.2. ~~Any person with a five percent (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, policy will be updated to reflect the required process(es).~~

2. ~~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

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

H.

4. ~~The practitioner must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.~~
5. ~~CalOptima Health shall notify DHCS upon initiation of each criminal background check for a practitioner that has been designated as high risk.~~
6. ~~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~~

1. ~~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.~~
2. ~~CalOptima Health shall conduct post enrollment site visits for medium risk practitioners at least every five (5) years and their high risk 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.~~
3. ~~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.~~

Federal and State Database Checks

1. CalOptima Health shall check the following databases to verify the identity and determine the sanction, exclusion, debarment and/or enrollment status of all practitioners:
 - 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 (S&I) Provider List;
 - g. Restricted Provider Database (RPD);
 - h. Preclusion List;
 - g-i. Medicare Opt Out report; and
 - h-j. CHHS Open Data Portal.
2. CalOptima Health shall also review the SAM, LEIE, RPD, and RPDother 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 any sanction, exclusion, or debarment.
3. 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 of that practitioner.~~
 - ~~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. 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.~~

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

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

IV. ATTACHMENT(S)

~~A. CalOptima Health Primary Source Verification Table~~
~~Not Applicable~~

V. REFERENCE(S)

- A. Assembly Bill (AB) 1041
- B. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
- C. California Evidence Code §1157
- D. California Health & Safety Code §§1374.197, 1374.198, and 1380.2
- E. CalOptima Health Contract for Health Care Services
- F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
- G. CalOptima Health Contract with Covered California
- H. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- I. CalOptima Health PACE Program Agreements
- J. CalOptima Health Policy GG.1213: Community Health Worker Services
- ~~K. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice~~
- ~~L.K.~~ CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
- ~~M.L.~~ CalOptima Health Policy GG.1607: Monitoring Adverse Actions
- ~~N.M.~~ CalOptima Health Policy GG.1608: Full Scope Site Reviews
- ~~O.N.~~ CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
- ~~P. CalOptima Health Policy GG.1619: Delegation Oversight~~
- ~~Q.O.~~ CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
- ~~R.P.~~ CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
- ~~S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers~~
- ~~T.Q.~~ CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
- ~~U.R.~~ CalOptima Health Policy GG.1707: Doula Services
- ~~V. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint~~
- ~~W.S.~~ CalOptima Health Policy MA.5012: Pharmacy Network: Credentialing and Access
- ~~X. CalOptima Health Policy MA.9006: Provider Complaint Process~~
- ~~Y. 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 01/02/2025)
- 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) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members

- X. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
- Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
- Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-015: Immunization Requirements (Supersedes APL 24-008)
- U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
- V. National Committee for Quality Assurance (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
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
04/02/2026	Regular Meeting of the CalOptima Health 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

Action	Date	Policy	Policy Title	Program(s)
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
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
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
<u>Revised</u>		<u>GG.1650</u>	<u>Credentialing and Recredentialing of Practitioners</u>	<u>Covered California</u> <u>Medi-Cal</u> <u>OneCare</u> <u>PACE</u>

1 IX. GLOSSARY
2

Term	Definition
Abuse	<u>Covered California</u>: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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)	<u>Covered California</u>: 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 required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. <u>Medi-Cal</u>: 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).

Term	Definition
	<u>OneCare</u>: 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. <u>PACE</u>: 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 § 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.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered California: <i>Effective 01/01/2027 for CalOptima Health</i>	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	<u>Covered California</u>: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. <u>Medi-Cal</u>: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. <u>OneCare</u>: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. <u>PACE</u>: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.

Term	Definition
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 (CVO)	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.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
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 primary care physicians (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.
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 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	<u>Covered California:</u> A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but 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.

Term	Definition
	<u>Medi-Cal</u>: 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. <u>OneCare</u>: 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. <u>PACE</u>: 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 § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, 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.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical

Term	Definition
	education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
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 § 1603.
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	An individual 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.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
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.
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 BPC § 3502 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

Term	Definition
	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 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 PCP.
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.
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	<u>Covered California</u>: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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.



Policy: GG.1650
Title: **Credentialing and Recredentialing of Practitioners**
Department: Quality Improvement
Section: Not Applicable

CEO Approval: /s/

Effective Date: 06/01/2017

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether 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 Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.
 1. Delegates shall perform functions that, at minimum, meet the requirements as outlined in this policy.
 2. CalOptima Health may accept evidence of National Committee for Quality Assurance (NCQA) Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.
- C. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring Credentialing policies are adhered to.
- D. CalOptima Health's CMO or Designee, or CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health, consistent with Department of Health Care Services (DHCS), NCQA, Department of Managed Health Care (DMHC), and Centers for Medicare & Medicaid (CMS) regulations and standards. The initial Credentialing decision is valid for a period of three (3) years.

- 1 E. CalOptima Health and its Delegates shall ensure that any practitioner in its Medi-Cal provider
2 network for whose provider type has an enrollment pathway with DHCS is screened and enrolled with
3 DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider
4 Credentialing/Recredentialing and Screening /Enrollment, including any superseding APL, and Title
5 42, CFR, Part 455.
6
7 1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment
8 Division (PED) or another state department with a recognized enrollment pathway, such as
9 California Department of Public Health (CDPH).
10
11 2. CalOptima Health may enroll practitioners through the screening and enrollment process outlined
12 in Section III.G, in compliance with DHCS requirements, or CalOptima Health may direct
13 network practitioners to enroll through a state-level enrollment pathway.
14
15 3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-
16 Cal but must comply with CalOptima Health's vetting process.
17
18 F. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to
19 participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a
20 pending enrollment application in review with DHCS' PED or a DHCS approved screening and
21 enrollment process.
22
23 1. CalOptima Health and its Delegates shall terminate its contract with the practitioner no later than
24 fifteen (15) calendar days of the practitioner receiving notification from DHCS that the
25 practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the
26 first one hundred twenty (120) calendar day period.
27
28 2. CalOptima Health and its Delegates shall not continue to contract with a practitioner during the
29 period in which the practitioner resubmits its enrollment application to DHCS or approved
30 screening and enrollment process and shall only reinstate a contract upon the practitioner's
31 successful enrollment as a Medi-Cal practitioner.
32
33 3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior
34 to terminating the practitioner and shall submit a plan of action for continuity of services for
35 review and approval before the termination.
36
37 G. CalOptima Health and its Delegates shall credential, prior to services being rendered, and recredential
38 all contracted practitioners that render services to Members and are:
39
40 1. Licensed, certified, or registered by the state of California to practice independently (without
41 direction or supervision);
42
43 a. CalOptima Health shall not require the licensure of a health professional employed by a tribal
44 health program under the state or local law where the Tribal Health Program is located, if the
45 professional is licensed in another state, in accordance with 25 United States Code (USC) §
46 1621t.
47
48 b. CalOptima Health and its Delegates shall allow out-of-state licensed psychologists, clinical
49 social workers, marriage and family therapists, or professional clinical counselors to provide
50 Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal
51 program with an approved Professional Licensing Waiver (PLW) from DHCS.
52

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 Care and Specialty Care services);
 3. In an independent relationship with CalOptima Health;
 - a. An independent relationship exists when CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and
 4. Providing care to Members under CalOptima Health's programs.
- H. CalOptima Health and its Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:
1. Individual or group practices;
 2. Locum Tenens;
 3. Facilities;
 4. Telemedicine/telehealth (i.e., virtual care visit); or
 5. Rental and preferred provider organization networks.
- I. CalOptima Health and its Delegates shall credential and recredential the following practitioners including, but not limited to:
1. Medical Doctor (MD);
 2. Doctor of Osteopathy (DO);
 3. Doctor of Chiropractic Medicine (DC);
 4. Doctor of Dental Surgery (DDS);
 5. Doctor of Podiatric Medicine (DPM);
 6. Nurse Practitioners (NP); and
 7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant, Midwife, Physical Therapist, etc.)
 - a. Behavioral health practitioners, including but not limited to:
 - i. Psychiatrists and other physicians;
 - ii. Addiction medicine specialists;
 - iii. Doctoral or master's level psychologists;
 - iv. Master's-level clinical social workers;

- 1
2 v. Master's-level clinical nurse specialists or psychiatric nurse practitioners; and
3
4 vi. Other behavioral healthcare specialists who may be within the scope of credentialing
5 (e.g., licensed professional counselors, qualified autism services (QAS) providers also
6 known as applied behavior analysis (ABA) practitioners).
7
- 8 J. CalOptima Health and its Delegates shall credential and recredential Non-Physician Medical
9 Practitioners (NMP) who meet license and state board requirements for the scope of their practice and
10 who do not have an independent relationship with CalOptima Health.
11
- 12 1. Credentialed and recredentialed NMPs include:
13
14 a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed
15 Physician Practitioner and have executed a signed agreement as required by the applicable
16 state of California board with the NMP;
17
18 i. Physician supervision is not required for services rendered by certain classes of Nurse
19 Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103
20 and 2837.104;
21
22 b. NMPs who provide services as part of an Organized Health Care System that is credentialed
23 with CalOptima Health and have a signed agreement, as required by the applicable state of
24 California licensing board, between the NMP and the Organized Health Care System; or
25
26 c. NMPs who are not Physician Assistants (PAs) and who provide services under the
27 employment agreement of a credentialed Physician Practitioner.
28
- 29 2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no
30 longer meets the CalOptima Health Credentialing requirements, or if there is a change in the
31 supervising Physician Practitioner, or NMP's employment with the entity or Organized Health
32 System.
33
- 34 K. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not
35 have a corresponding state-level enrollment pathway, CalOptima Health shall at minimum verify the
36 qualifications and vet the practitioner for the following:
37
- 38 1. Sufficient experience to provide services similar to the services for which they are contracted to
39 provide within the service area;
40
41 2. Business licensing that meets industry standards, if applicable;
42
43 3. No history of Fraud, Waste, and/or Abuse;
44
45 4. No recent history of criminal activity, including a history of criminal activities that endanger
46 Members and/or their families, which is completed by the contracted organization and validated
47 through an attestation;
48
49 5. Review of history of liability claims against the practitioner; and
50
51 6. Review of federal and state exclusion, sanction, and debarment sources.
52

1 M. CalOptima Health does not credential or recredential:

- 2
- 3 1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists, intensivists,
- 4 pathologists, etc.) and provide care for a Member only as a result of the Member being directed to
- 5 the hospital or inpatient setting.
- 6
- 7 2. Practitioners who practice exclusively within freestanding facilities and provide care for a
- 8 Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists,
- 9 urgent care, emergency medicine).
- 10
- 11 3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health
- 12 delegates Utilization Management functions (Credentialing of pharmacies and their professional
- 13 and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy
- 14 MA.5012: Pharmacy Network Credentialing and Access).
- 15
- 16 4. Covering practitioners who do not have an independent relationship with CalOptima Health.
- 17
- 18 5. Practitioners who do not provide care for a Member in a treatment setting (*e.g.*, external physician
- 19 reviewer).
- 20
- 21 6. Health care professionals who are permitted to furnish services only under the direct supervision
- 22 of another practitioner.
- 23
- 24 7. Students, residents, and fellows, where applicable.
- 25
- 26 8. Rental network practitioners who provide out-of-area care only, and Members
- 27 are not required or given an incentive to seek care from them.
- 28
- 29 9. Health care professionals who are permitted to furnish services as part of a letter of agreement
- 30 (LOA) or a continuity of care arrangement.
- 31

32 N. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified

33 Health Centers (FQHCs) and FQHC Look-Alikes and does not credential or recredential medical

34 practitioners who practice exclusively within a FQHC or FQHC Look-Alikes and who provide care

35 for a Member only as a result of the Member being directed to the FQHC or FQHC Look-Alikes.

36

37 O. CalOptima Health and its Delegates shall recredential a practitioner at least every three (3) years,

38 utilizing a thirty-six (36) month cycle to the month, not to the day.

39

40 P. CalOptima Health and its Delegates shall ensure that all practitioners maintain current California

41 licensure, as applicable, and shall monitor various state and federal boards, agencies, and databanks

42 for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse

43 Actions.

44

45 Q. CalOptima Health and its Delegates shall notify the practitioner, in writing, of the Credentialing or

46 Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the

47 application.

48

49 R. CalOptima Health and its Delegates shall not discriminate against any practitioner during the

50 Credentialing and Recredentialing process.

51

1. CalOptima Health and its Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their 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:
 - a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;
 - b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and
 - c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.
 2. CalOptima Health and its Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.
 3. CalOptima Health and its Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.
- S. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information.
- T. CalOptima Health and its Delegates 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 CMO or its designee or CPRC.
1. CalOptima Health and its Delegates shall notify the Covered California practitioner within ten (10) business days from receipt of an application and completion of primary source verification to verify receipt and inform the applicant whether the application is complete.
 2. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare, or PACE practitioner within thirty (30) calendar days from receipt of an application and completion of primary source verification to verify receipt and inform the applicant whether the application is complete.
 3. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will be discontinued.
- U. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) 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.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

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- a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or its Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.
 - b. CalOptima Health and its Delegates shall utilize the most recent versions of DataSpring (also referred to as the Council for Affordable Quality Health Care (CAQH)) credentialing form and processes for Credentialing and Recredentialing. CalOptima Health and/or its Delegates shall only request additional information from an applicant practitioner to clarify and confirm information that is provided on the CAQH credentialing form, including verification of information not specifically disclosed on the practitioner's application.
 - c. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.
 - d. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.
 - e. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.
 - f. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health Practitioner in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.
 - i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health Practitioner whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.
 - g. 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 DHCS APL 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.
 - h. Practitioners shall attest to:
 - i. Any work history gap that exceed six (6) months must include 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.
- i. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).
- j. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.
- k. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.
- l. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.
- m. If the required information is not received within sixty (60) 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.
- n. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the 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 Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.
- o. A PA who does not have an independent relationship with CalOptima Health or a Delegate 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; statement that 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 Physician 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, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary source using NCQA-accepted and/or industry-recognized verification sources. 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 (verification time limit: 120 calendar days);
 - b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days);
 - 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;
 - d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;
 - e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and
 - f. Is not currently on the Medicare Opt Out list.
3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source (see Attachment A). 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 a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);
 - b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;
 - i. History of any suspension or curtailment of hospital 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/or 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. This requirement is not applicable for practitioners who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written description of their process for handling instances when a patient requires a controlled substance.

- 1 d. Current malpractice insurance in the minimum amounts of one million dollars
2 (\$1,000,000.00) per occurrence and three million dollars (\$3,000,000.00) aggregate per year
3 at the time of the Credentialing decision (verification time limit: 120 calendar days);
4
5 i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one
6 million dollars (\$1,000,000.00) per incident and one million dollars (\$1,000,000.00)
7 aggregate per year at the time of the Credentialing decision (verification time limit: 120
8 calendar days).
9
10 e. PractitionerNational Practitioner Data Bank (NPDB) Continuous Query (CQ) (verification
11 time limit: 120 calendar days) if applicable;
12
13 f. No current exclusion or preclusion from participation in federal or state health care programs
14 based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as
15 follows:
16
17 i. A conviction of a criminal offense related to the delivery of an item, or service, under
18 federal, or state, health care programs;
19
20 ii. A felony conviction related to neglect or abuse of patients in connection with the delivery
21 of a health care item or service;
22
23 iii. A felony conviction related to health care fraud; or
24
25 iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or
26 dispensing of a controlled substance.
27
28 g. History of professional liability claims that resulted in settlements or judgments paid by, or on
29 behalf of, the practitioner in the last five (5) years;
30
31 h. History of state sanctions, restrictions on licensure, or limitations on scope of practice, which
32 may include probation, a previously filed 805 and/or 805.1 report with a licensing board; and
33
34 i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.
35
36 4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner
37 types in the Medi-Cal provider network in accordance with the following CalOptima Health
38 policies:
39
40 a. For Doulas, compliance with the requirements, in accordance with CalOptima Health Policy
41 GG.1707: Doula Services.
42
43 b. For Community Health Workers (CHW), compliance with the requirements in accordance
44 with CalOptima Health Policy GG.1213: Community Health Worker Services.
45
46 5. CalOptima Health, a Delegate, or CVO shall have appropriate documentation in the credentialing
47 files using either of the following methods or a combination:
48
49 a. Credentialing documents signed (or initialed) and dated by the verifier
50
51 b. A checklist that includes, for each verification:
52

- i. The source used;
 - ii. The date of verification;
 - iii. The signature or initials of the person who verified the information;
 - iv. Typed initials are only accepted if there is a unique electronic signature or identifier on the checklist; and
 - v. The report date, if applicable.
- c. A checklist with a single signature and a date for all verifications that includes a statement confirming that the signatory verified all credentials on that date and that includes for each verification:
- i. The source used; and
 - ii. The report date, if applicable.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:
 - a. Collect and/or verify, where applicable, at a minimum, all of the information required for Credentialing, as set forth in Section III.A. 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. 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 twenty (120) 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. Member satisfaction, if applicable; and
 - v. Compliance with the terms of the practitioner's contract.
 - c. All Recredentialing applications must include the attestations as contained in the practitioner's Credentialing 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 or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing.
4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.
 - a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.
 - b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to Policy GG.1607 Monitoring Adverse Actions.
5. CalOptima Health, a Delegate, or CVO shall have appropriate documentation in the credentialing files using either of the following methods or a combination:
 - a. Credentialing documents signed (or initialed) and dated by the verifier; and
 - b. A checklist that includes, for each verification:
 - i. The source used;
 - ii. The date of verification;
 - iii. The signature or initials of the person who verified the information; and
 - iv. Typed initials are only accepted if there is a unique electronic signature or identifier on the checklist
 - v. The report date, if applicable
 - c. A checklist with a single signature and a date for all verifications that includes a statement confirming that the signatory verified all credentials on that date and that includes for each verification:
 - i. The source used; and
 - ii. The report date, if applicable.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:
 - a. Right to review information:
 - i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards, exclusion,

1 sanction and debarment sources, etc.), but does not extend to review of information,
2 references, or recommendations protected by law from disclosure (*i.e.*, peer-review
3 protected information).
4

5 b. Right to correct erroneous information:
6

- 7 i. All practitioners will be notified by email or certified mail when Credentialing or
8 Recredentialing information obtained from sources during Credentialing or
9 Recredentialing varies from that provided by the practitioner in the Credentialing or
10 Recredentialing application;
11
- 12 ii. All practitioners have the right to correct erroneous information, as follows:
13
- 14 a) The practitioner has forty-eight (48) hours, excluding weekends, from date of
15 notification to correct erroneous information;
16
- 17 b) Requests for correction of erroneous information must be submitted by email or
18 certified mail on the practitioner's letterhead with a detailed explanation regarding
19 the erroneous information, as well as copy(ies) of corrected information; and
20
- 21 c) For practitioners credentialed directly CalOptima Health, mailed submissions must be
22 sent to CalOptima Health's Quality Improvement (QI) Department using the
23 following address or email:
24
- 25 Attn Quality Improvement Department – Credentialing
26 CalOptima Health
27 505 City Parkway West
28 Orange CA 92868
29
- 30 Email: mycredentialingupdates@caloptima.org
31
- 32 d) For practitioners credentialed by a Delegate, the practitioner shall contact their
33 Delegate directly to address any erroneous information.
34
- 35 iii. CalOptima Health is not required to reveal the source of information, if the information is
36 not obtained to meet CalOptima Health's Credentialing or Recredentialing verification
37 requirements, or if federal or state law prohibits disclosure.
38
- 39 iv. Documentation of receipt of corrections:
40
- 41 a) CalOptima Health or its Delegate shall document receipt of corrected information in
42 the practitioner's Credentialing or Recredentialing file.
43
- 44 b) A practitioner shall be notified via fax, email, or certified letter to document receipt
45 of the identified erroneous information.
46
- 47 v. Right to be notified of application status
48
- 49 a) Practitioners may receive the status of their Credentialing or Recredentialing
50 application, upon written request.
51

- 1 b) Practitioners can contact the QI Department by email requesting the status of their
2 application. The QI Department will aim to respond within seven (7) business day of
3 the status of the practitioner's application with respect to outstanding information
4 required to complete the application process.
5

6 D. Credentialing Committee
7

- 8 1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-
9 review process to make recommendations and decisions regarding credentialing and
10 recredentialing.
11
12 2. CalOptima Health shall designate the CPRC that uses a peer-review process to make
13 recommendations and decisions regarding Credentialing and Recredentialing for practitioners in
14 CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for
15 the Elderly.
16
17 3. CPRC shall include representation from a range of practitioners participating in the organization's
18 network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing
19 files and determining the practitioner's participation in CalOptima Health programs.
20
21 4. Completed Credentialing and Recredentialing files will either be presented to the CMO or
22 Designee on a clean file list for signature or will be presented at CPRC for review and approval.
23
24 a. A clean file consists of a complete application with a signed attestation and consent form,
25 supporting documents, and verification of no more than one (1) professional review or
26 malpractice claim(s) that resulted in settlements or judgments greater than twenty-five
27 thousand dollars (\$25,000) paid by, or on behalf of, the practitioner within the last seven (7)
28 years from the date of the Credentialing or Recredentialing review.
29
30 i. A clean file shall be considered approved and effective on the date that the CMO or
31 Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file.
32
33 ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for to
34 be reflected in the meeting minutes.
35
36 b. Files that do not meet the clean file review process and that require further review by CPRC
37 include, but are not limited to, those files that include more than one (1) malpractice claim
38 that resulted in a settlement or judgment greater than twenty-five thousand dollars (\$25,000),
39 or NPDB CQ identifying investigations, or other actions.
40
41 i. Files that do not meet clean file criteria will be reviewed by CPRC for determination to
42 accept, or deny, the application.
43
44 ii. CPRC shall give thoughtful consideration to the information presented in the
45 Credentialing or Recredentialing file, which shall be reflected in the minutes of the CPRC
46 meeting.
47
48 iii. CPRC meetings and decisions may take place in person, or as a virtual meeting via
49 telephone or video conference but may not be conducted via email.
50
51 5. Practitioner files identified as not meeting Credentialing or Recredentialing criteria with
52 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 CMO or Designee for review.

- a. The CMO or Designee shall review each practitioner file who does not meet Credentialing or Recredentialing criteria and make recommendations regarding approval or denial of Credentialing or Recredentialing of the practitioner to the CPRC. For practitioner files which do not meet criteria on an administrative basis only, (e.g., does not meet standard requirements to be considered for Credentialing or Recredentialing) the file may be approved or denied by the CMO or Designee.
6. The CPRC shall make a final determination based on the practitioner's ability to deliver care based on the Credentialing or Recredentialing information collected from the file review process which is verified prior to the Credentialing or Recredentialing decision.
- a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:
 - i. Acceptance;
 - ii. Acceptance for less than three (3) years;
 - iii. Acceptance with specific conditions, which shall not be defined as restrictions and are not reportable to the NPDB and/or under 805 or 805.1 requirements;
 - iv. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or
 - v. 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 and its Delegates shall make a determination regarding the credentials of a Covered California practitioner within ninety (90) days after receiving a completed practitioner credentialing application, including all required third-party verifications. CalOptima Health and its Delegates shall notify a practitioner, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the practitioner's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:
 - i. The practitioner is subject to discipline by the licensing entity for the practitioner.
 - ii. The practitioner has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).
 - iii. The practitioner has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.
 - c. CalOptima Health shall render a final Credentialing or Recredentialing decision for Medi-Cal, OneCare and PACE practitioners within one hundred twenty (120) calendar days from the

1 date of a completed application, which includes a signed attestation that confirms the
2 correctness and completeness of the application.

- 3
4 i. Application attestations must be signed within one hundred eighty (180) calendar days
5 prior to the Credentialing or Recredentialing decision. If the practitioner's attestation
6 expires prior to the Credentialing decision, the practitioner must reattest that the
7 information on the application remains correct and complete, by resigning and redating
8 the attestation.
9
10 ii. As of January 1, 2027, CalOptima Health and its Delegates shall notify the practitioner
11 within ten (10) business days to verify receipt and inform the applicant whether the
12 application is complete, which includes collection of the application and third-party
13 verifications.
14

- 15 7. If CalOptima Health terminates a practitioner during the Recredentialing process for
16 administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information)
17 and not for quality reasons (*i.e.*, medical disciplinary cause or reason), CalOptima Health may
18 reinstate the practitioner within thirty (30) calendar days of termination and is not required to re-
19 perform Credentialing. However, CalOptima Health must reverify credentials that are no longer
20 within the verification time limit. If the reinstatement is more than thirty (30) calendar days after
21 termination, CalOptima Health must perform Credentialing of such practitioner.
22

- 23 a. Termination includes failure or refusal to renew a contract or to renew, extend, or reestablish
24 such, if the action is based on medical disciplinary cause or reason.
25

- 26 E. CalOptima Health and its Delegates shall monitor and prevent discriminatory practices. Activities,
27 including, but are not limited to:
28

29 1. Monitoring:
30

- 31 a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to
32 ensure that practitioners are not discriminated against as set forth in Section II.Q.;
33
34 b. Review practitioner complaints to determine if there are complaints alleging discrimination;
35 and
36
37 c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential
38 quality-of-care issues for complaints alleging discrimination and will report outcomes to the
39 CPRC for review and determination.
40

41 2. Prevention:
42

- 43 a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible
44 for Credentialing decisions to sign a statement affirming that they do not discriminate.
45
46 b. QI Department staff shall remove identifying information, such as name, gender, National
47 Provider Identifier (NPI) and group affiliation, from practitioner files when presenting cases
48 to CPRC to remove bias and prevent discrimination.
49

- 50 F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the
51 Credentialing or Recredentialing profile with the Contracting, Provider Relations, and Provider Data
52 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 or Recredentialing process (*i.e.*, education, training, board certification, and specialty). PDMS will enter the contract and elements of Credentialing or Recredentialing data into CalOptima Health's core business system(s) and/or will verify the Credentialing data in such systems, as needed, and updates pertinent information for propagation to the printed and/or online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a DHCS PED approval letter as an acceptable form of initial enrollment verification.
2. If a practitioner is not already enrolled with DHCS as a Medi-Cal Fee For Service (FFS) practitioner CalOptima Health does not complete screening and enrollment established by CalOptima Health. If CalOptima Health chooses to complete DHCS screening and enrollment, this policy will be updated to reflect the required process(es).

H. Federal and State Database Checks

1. CalOptima Health shall check the following databases to verify the identity and determine the sanction, exclusion, debarment and/or enrollment status of all practitioners:
 - 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 (S&I) Provider List;
 - g. Restricted Provider Database (RPD);
 - h. Preclusion List;
 - i. Medicare Opt Out report; and
 - j. CHHS Open Data Portal.
2. CalOptima Health shall also review the SAM, LEIE, RPD, and other 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 any sanction, exclusion, or debarment.
3. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.
 - a. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

1
2 **IV. ATTACHMENT(S)**
3

4 Not Applicable
5

6 **V. REFERENCE(S)**
7

- 8 A. Assembly Bill (AB) 1041
9 B. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
10 C. California Evidence Code §1157
11 D. California Health & Safety Code §§1374.197, 1374.198, and 1380.2
12 E. CalOptima Health Contract for Health Care Services
13 F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare
14 Advantage
15 G. CalOptima Health Contract with Covered California
16 H. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
17 I. CalOptima Health PACE Program Agreements
18 J. CalOptima Health Policy GG.1213: Community Health Worker Services
19 K. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing
20 Activities
21 L. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
22 M. CalOptima Health Policy GG.1608: Full Scope Site Reviews
23 N. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
24 O. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
25 P. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
26 Q. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
27 R. CalOptima Health Policy GG.1707: Doula Services
28 S. CalOptima Health Policy MA.5012: Pharmacy Network: Credentialing and Access
29 U. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing /
30 Recredentialing and Screening / Enrollment (Revised 01/02/2025)
31 V. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services
32 (Supersedes APL 22-031) (Revised 11/03/2023)
33 W. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care
34 Plan Responsibilities for Indian Health Care Providers and American Indian Members
35 X. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health
36 Worker Services Benefit (Supersedes APL 22-016)
37 Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's
38 Services Whole Child Model Program (Supersedes APL 23-034)
39 Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-015: Immunization
40 Requirements (Supersedes APL 24-008)
41 U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
42 V. National Committee for Quality Assurance (NCQA) Standards and Guidelines
43 W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64,
44 460.71, and Part 455, Subpart E
45 X. Title 42, United States Code (USC), §1320a-7(a)
46 Y. Title XVIII and XIV of the Social Security Act
47

48 **VI. REGULATORY AGENCY APPROVAL(S)**
49

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
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
04/02/2026	Regular Meeting of the CalOptima Health 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
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

Action	Date	Policy	Policy Title	Program(s)
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
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised		GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

1

For October

1 IX. GLOSSARY
2

Term	Definition
Abuse	<u>Covered California</u>: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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)	<u>Covered California</u>: 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 required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. <u>Medi-Cal</u>: 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).

Term	Definition
	<u>OneCare</u>: 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. <u>PACE</u>: 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 § 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.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered California: <i>Effective 01/01/2027 for CalOptima Health</i>	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	<u>Covered California</u>: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. <u>Medi-Cal</u>: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. <u>OneCare</u>: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. <u>PACE</u>: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.

Term	Definition
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 (CVO)	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.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
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 primary care physicians (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.
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 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	<u>Covered California:</u> A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but 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.

Term	Definition
	<u>Medi-Cal</u>: 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. <u>OneCare</u>: 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. <u>PACE</u>: 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 § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, 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.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical

Term	Definition
	education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
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 § 1603.
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	An individual 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.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
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.
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 BPC § 3502 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

Term	Definition
	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 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 PCP.
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.
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	<u>Covered California</u>: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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.



Policy: GG.1651
Title: **Assessment and Reassessment of Organizational Providers**
Department: Quality Improvement
Section: Not Applicable

CEO Approval: /s/

Effective Date: 06/01/2017

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

- A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.
- B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the ~~follow~~following shall occur:
 1. The delegation shall 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 the 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 policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

- 1 C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or
2 Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605:
3 Delegation and Oversight of Credentialing and Recredentialing Activities.
4
- 5 1. A Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet
6 the requirements as outlined in this policy.
7
- 8 D. The Chief Medical Officer (CMO) or Designee, or the CalOptima Health Credentialing and Peer
9 Review Committee (CPRC) shall have direct responsibility over and shall actively participate in the
10 assessment and ~~Reassessment~~reassessment of an OP. The initial Credentialing decision is valid for a
11 period of three (3) years.
12
- 13 E. ~~The CalOptima Health Credentialing and Peer Review Committee (CPRC)~~The CPRC shall be
14 responsible for reviewing an OP's application information and CalOptima Health's findings for
15 determining an OP's participation in CalOptima Health's Provider network, consistent with DHCS,
16 National Committee for Quality Assurance (NCQA), and Department of Managed Health Care
17 (DMHC), and Centers for Medicare and Medicaid (CMS) regulations and standards. No later than
18 January 1, 2028, the CPRC shall use up-to-date ~~CAQH~~Council for Affordable Quality Healthcare
19 (CAQH) credentialing forms and processes – as applicable and available – to credential and
20 recredential OPs and only request additional information from an OP to clarify and confirm
21 information provided on the applicable and available CAQH credentialing form.
22
- 23 F. CalOptima Health shall assess or reassess OPs, including, but not limited to, the following:
24
- 25 1. Acute Rehabilitation Facilities;
 - 26
 - 27 2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
 - 28
 - 29 3. Birthing Centers;
 - 30
 - 31 4. Certified Hospice Providers;
 - 32
 - 33 5. Chronic Dialysis Clinic;
 - 34
 - 35 6. Clinical/Medical Laboratory;
 - 36
 - 37 7. Community Based Adult Services (CBAS) Providers;
 - 38
 - 39 8. Community Clinic;
 - 40
 - 41 9. Dialysis (End-Stage Renal Disease) Center/Facility;
 - 42
 - 43 10. Customized/Durable Medical Equipment (DME) Providers;
 - 44
 - 45 11. Federally Qualified Health Center (FQHC);
 - 46
 - 47 12. FQHC Look-Alikes
 - 48
 - 49 13. Free ~~Clinic~~Clinics;
 - 50
 - 51 14. Health Access ~~Program~~Programs;
 - 52

15. Home Health Agencies;
 16. Hospice and Palliative Care Providers;
 17. Hospitals;
 18. Indian Health Care Providers or Facilities;
 19. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
 20. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;
 - a. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.
 21. Non-Emergency Medical Transportation;
 22. Prosthetics and Orthotics;
 23. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;
 24. Radiology ~~Center~~Centers (Free Standing);
 25. Rehabilitation ~~Center~~Clinic~~Centers~~Clinics (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);
 26. Religious Non-Medical Health Care ~~Institution~~Institutions;
 27. Residential Care Facilities for the Elderly;
 28. Rural Health ~~Clinic~~Clinics (RHC);
 29. Skilled Nursing Facilities/Long Term Care ~~Facility~~Facilities;
 30. Surgical ~~Center~~Centers (Free Standing);
 31. Transplant Programs (Organ Procurement Organization); ~~and~~
 32. Urgent Care ~~Center~~Centers (Free Standing); ~~and~~
 33. Medical Groups
 - a. Medical groups shall prohibit employment or contracting with practitioners or OPs (or entities that employ or contract with such practitioners or OPs) that are Excluded/sanctioned from participation in Medicare or Medi-Cal or are Excluded on any other state or federal Exclusion, sanction, restriction or Preclusion list.
- G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/

1 Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part
2 455, and as described in Sections III.A. and III.B. of this Policy.

- 3
4 1. State-level enrollment pathways are available either through the DHCS Provider Enrollment
5 Division (PED) or another state department with a recognized enrollment pathway-, such as
6 California Department of Public Health (CDPH).
7
8 2. CalOptima Health may enroll ~~providers~~Providers through the screening and enrollment process
9 outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may
10 direct network Providers to enroll through a state-level enrollment pathway.
11
12 3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-
13 Cal but must comply with CalOptima Health's vetting process.
14
15 4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case
16 agreements with out-of-state transplant programs.
17
18 H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment
19 pathway, including but not limited to Community Supports Providers (e.g., housing agencies,
20 medically tailored meal programs), and certain Enhanced Care Management (ECM) Providers, are not
21 required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the
22 Provider or Provider organization to ensure Providers have:
23
24 1. Sufficient experience to provide services similar to the specific service for which they are
25 contracted to provide within the service area;
26
27 2. Business licensing that meets industry standards;
28
29 3. ~~History~~No history of ~~fraud, waste~~Fraud, Waste, and/or ~~abuse~~Abuse;
30
31 4. ~~Recent~~No recent history of criminal activity, including a history of criminal activities that
32 endanger Members and/or their families; ~~and~~
33
34 5. HistoryReview of history of liability claims against the Provider; and
35
36 5-6. Review of federal and state exclusion, sanction, and debarment sources.
37
38 I. CalOptima Health and its Delegates may allow Providers in its Medi-Cal provider network to
39 participate in the network for up to one hundred twenty (120) calendar days if the Provider has a
40 pending enrollment application in review with DHCS' PED or a DHCS approved screening and
41 enrollment process.
42
43 1. CalOptima Health and its Delegates shall terminate its contract with the Provider no later than
44 fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has
45 been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred
46 twenty (120) calendar day period.
47
48 2. CalOptima Health and its Delegates shall not continue to contract with a Provider during the
49 period in which the Provider resubmits its enrollment application to DHCS or approved screening
50 and enrollment process and shall only re-initiate a contract upon the Provider's successful
51 enrollment as a Medi-Cal Provider.
52

- 1 3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to
2 terminating the Provider and shall submit a plan of action for continuity of services for review
3 and approval before the termination.
4
- 5 J. CalOptima Health and its Delegates shall require that the OP be successfully assessed prior to
6 contracting and every three (3) years thereafter, except as otherwise specified in this policy.
7
- 8 1. CalOptima Health and its Delegates shall confirm that the OP is in good standing with state and
9 federal regulatory agencies,
10
- 11 2. CalOptima Health and its Delegates shall require OPs to be reviewed and approved by an
12 accrediting body or have received an on-site quality assessment consistent with the provisions of
13 this policy if the Provider is not accredited, as applicable.
14
- 15 K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and its
16 Delegates shall confirm:
17
- 18 1. Medi-Cal participation status of the OP and
19
- 20 2. Medicare participation status for the following OPs:
21
- 22 a. Hospitals;
23
- 24 b. Home Health Agencies (HHAs);
25
- 26 c. Hospices;
27
- 28 d. Clinical Laboratories;
29
- 30 e. Skilled Nursing Facilities (SNFs);
31
- 32 f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);
33
- 34 g. Outpatient Physical Therapy and Speech Pathology Providers;
35
- 36 h. Ambulatory Surgical Centers (ASCs);
37
- 38 i. Providers of end-stage renal disease services;
39
- 40 j. Providers of outpatient diabetes self-management training;
41
- 42 k. Portable x-ray suppliers;
43
- 44 l. Rural Health Clinic (RHCs); and
45
- 46 m. FQHCs; and
47
- 48 n. FQHC Look-Alikes.
49
- 50 L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima
51 Health or its Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason
52 for its decision.

- 1
2 M. No later than January 1, 2027, CalOptima and its Delegates shall make a determination regarding the
3 credentials of a Covered California OP within ninety (90) days after receiving a completed OP
4 credentialing application, including all required third-party verifications. CalOptima and its Delegates
5 shall notify an OP, if successfully approved, of the activation within ten (10) business days of
6 approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day
7 timeline shall apply only to the credentialing process and does not include contracting completion. If
8 CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the OP's credentials
9 shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:
10
11 1. The OP is subject to discipline by the licensing entity for the OP.
12
13 2. The OP has one or more adverse action reports or one or more reports of malpractice payments
14 filed with the National Practitioner Data Bank (NPDB).
15
16 3. The OP has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.
17
18 N. CalOptima and its Delegates shall make a determination regarding the credentials of a Medi-Cal,
19 OneCare or PACE OP within one hundred twenty (120) days after receiving a completed OP
20 credentialing application, including all required third-party verifications.
21
22 O. An OP shall have the right to file a complaint about the decision in accordance with CalOptima
23 Health Policies [CC.1202: CalOptima Health Covered Provider Complaint](#), HH.1101: CalOptima
24 Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.
25
26 P. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing files, in
27 accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing.
28

29 III. PROCEDURE

30 A. OP Initial Assessment

- 31
32
33 1. Upon notification of an intent to contract, CalOptima Health and its Delegates shall confirm the
34 OP is in good standing with state and/or federal regulatory agencies based on an examination of
35 the sources listed in Section III.A.2. of this policy.
36
37 2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along
38 with the following supplemental documentation:
39
40 a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable,
41 as part of the application;
42
43 b. OPs shall ensure that all information included in the assessment application is no more than
44 six (6) months old;
45
46 i. CalOptima Health and its Delegates shall return an incomplete application to an OP, and
47 such incomplete application will not be processed until the OP submits all the required
48 information.
49
50 ii. CalOptima Health and its Delegates shall notify the Covered California OP within ten
51 (10) business days to verify receipt and inform the applicant whether the application is
52 complete.

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- iii. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare or PACE OP within thirty (30) calendar days to verify receipt and inform the applicant whether the application is complete-.
 - iv. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the OP application withdrawn and will close the Credentialing file, if applicable.
 - v. If an OP application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.
 - c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (and/or business tax certificate), as applicable.
 - d. Accreditation and/or government-issued certification from the following entities, as applicable:
 - i. The Joint Commission (TJC) certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;
 - ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;
 - iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, (DME), prosthetics and orthotics supplies, and opioid treatment programs;
 - iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;
 - v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;
 - vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;
 - vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);
 - viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;
 - ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;
 - x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

- 1 xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging
2 Providers, and procedure-based modalities;
3
4 xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;
5
6 xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state
7 renal disease facilities; and
8
9 xiv. The ~~California Department of Public Health (CDPH)~~ for hospitals, ambulatory surgery
10 centers, home health agencies, hospices, dialysis centers, Community Based Adult
11 Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.
12
13 e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with
14 criteria for each type of Provider used for the assessment, and the process for ensuring that
15 the Providers credential their Practitioners;
16
17 i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.
18
19 a) The CMS or state quality review must be no more than three (3) years old. If the
20 review is older than three (3) years, then CalOptima Health shall conduct its own
21 onsite quality review.
22
23 ii. If a Provider has satellite facilities that follow the same policies and procedures as the
24 Provider, the site visits may be limited to a main facility.
25
26 f. Certificate of current professional liability insurance of at least the minimum amounts
27 required by provider type per the Contract for Health Care Services, as applicable;
28
29 g. ~~A copy of any~~ No history of sanctions, ~~Preclusions, Exclusions~~ preclusions, exclusions,
30 suspensions, or terminations from Medicare-and/or, Medi-Cal, or in federal or state health
31 care programs, as applicable;
32
33 h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;
34
35 i. Active panels with the California Children's Services Program, if applicable;
36
37 j. Staff roster and copy of all staff certifications, or licensure, if applicable;
38
39 k. A valid Type 2 National Provider Identifier (NPI) number; and
40
41 l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement
42 Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA
43 identification number.
44
45 3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for
46 community clinics and free-standing urgent care centers in providing services to Members in
47 CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608:
48 Full Scope Site Reviews to incorporate the documents to support review prior to approval
49 decisions.
50
51 4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied
52 signatures are acceptable; however, signature stamps are not acceptable.

- 1
2 5. CalOptima Health or its Delegates shall review the history of professional liability claims that
3 resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.
4

5 B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment
6

- 7 1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
8 seeking to participate in CalOptima Health's Medi-Cal program:
9
10 a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP
11 application, in accordance with Section III.A.2. of this policy.
12
13 b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities
14 for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization
15 and Transition of Members to Managed Care, or superseding APL, signed under penalty of
16 perjury attesting that the following Credentialing requirements are satisfied:
17
18 i. Completion of the CalOptima Health Provider training within the last two (2) years;
19
20 ii. A facility site audit from a state agency;
21
22 iii. No change in five percent (5%) ownership disclosure;
23
24 iv. Possession of an active CDPH license and CMS certification; and
25
26 v. In good standing as a Regional Center vendor.
27
28 c. W-9 request for taxpayer identification number and certification.
29
30 d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less
31 residents)).
32
33 e. Certificate of insurance for professional and general liability of at least the minimum amounts
34 required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.
35
36 f. No history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare,
37 Medi-Cal, or in federal or state health care programs, as applicable;
38

39 C. OP Reassessment
40

- 41 1. CalOptima Health or its Delegates shall reassess an OP at least every three (3) years after initial
42 assessment. At the time of Reassessment, CalOptima Health shall:
43
44 a. Collect and/or verify, at a minimum, all of the information required for initial assessment as
45 set forth in Section III.A. of this Policy;
46
47 b. Incorporate the following data in the decision-making process:
48
49 i. Quality review activities, including but not limited to:
50
51 a) Enrollment and other information from DHCS, CMS, or another agency, as
52 applicable;

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- b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;
 - c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and
 - d) Review of medical records, as applicable.
- ii. Member experience, if applicable;
 - iii. Liability claims history, if applicable; and
 - iv. Compliance with the terms of the Provider's contract.
- c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.
 - i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.
- 2. CalOptima Health or its Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.
- C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or its Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.
- D. Credentialing Committee
 - 1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.
 - 2. CalOptima Health's ~~Credentialing and Peer Review Committee (CPRC)~~ CPRC shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.
 - 3. Completed OP files will either be presented to the CMO or 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 signed application, required supporting documents that are current and valid, and verification that there have been no liability more than one (1) malpractice claim(s) that resulted in settlements a settlement or judgments judgment greater than twenty-five thousand dollars (\$25,000) paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment, or NPDB query identifying investigations or other actions, and confirmation that the OP is in good standing with state and federal regulatory agencies.

- 1
- 2 i. A clean file shall be considered approved and effective on the date that the CMO or
- 3 Designee, reviews and approves an OP's assessment and Reassessment file, and deems
- 4 the file clean.
- 5
- 6 ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for
- 7 final approval review and reflected in the meeting minutes.
- 8
- 9 b. Files that do not meet the clean file review process and require further review by CPRC
- 10 include but are not limited to those files that include a history of liability more than one
- 11 malpractice claim(s) that resulted in settlements, settlement, or judgments, judgment of more
- 12 than twenty-five thousand dollars (\$25,000), paid by or on behalf of the OP.
- 13
- 14 i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the
- 15 application. Files that are incomplete will not be processed until the Provider submits all
- 16 the required information.
- 17
- 18 ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information
- 19 presented in the file.
- 20
- 21 iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via
- 22 telephone or video conferencing, but may not be conducted through e-mail.
- 23
- 24 4. OP files identified as not meeting Credentialing criteria with exceptions or potential exceptions
- 25 shall be referred to the CMO or Designee for review.
- 26
- 27 a. The CMO or Designee shall review each file for OPs who do not meet Credentialing criteria
- 28 and make recommendations regarding approving or denying Credentialing of the Provider to
- 29 the CPRC. For OP files not meeting criteria on an administrative basis only, the file may be
- 30 approved or denied by the CMO or Designee.
- 31
- 32 5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health
- 33 programs based on the information reviewed as specified in this policy.
- 34
- 35 a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a
- 36 decision letter within thirty (30) calendar days of the decision indicating:
- 37
- 38 i. Acceptance; ~~or~~
- 39
- 40 ii. Acceptance for less than three (3) years;
- 41
- 42 iii. Acceptance with specific conditions, which shall not be defined as restrictions and are not
- 43 reportable to the NPDB and/or under 805 or 805.1 requirements; or
- 44
- 45 ~~iv.~~ Denial of the application, along with information regarding the right to file a complaint,
- 46 with a letter of explanation forwarded to the applicant.
- 47
- 48 b. CalOptima Health shall activate the Covered California OP upon successful approval if the
- 49 approval occurs prior to the end of the ninety (90)-day timeline from receipt of a completed
- 50 application.
- 51

- 1 6. Upon acceptance of the participation application, the CalOptima Health Quality Improvement
2 Department shall generate a Provider profile and forward the Provider profile to the Contracting,
3 Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS
4 Department will enter the contract and Provider data into CalOptima Health's core business
5 system, which updates pertinent information into the online Provider Directory.
6

7 E. Provider Screening and Enrollment (Medi-Cal Providers Only)
8

- 9 1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data
10 Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a
11 PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.
12
- 13 2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider
14 screening and enrollment process does not need to be completed by CalOptima Health.
15
- 16 3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, ~~then the~~ CalOptima
17 Health ~~may~~does not complete screening and enrollment established by CalOptima Health. If
18 CalOptima Health chooses to complete DHCS screening and enrollment, this policy will be
19 updated to reflect the required process(es).
20
- 21 ~~a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to~~
22 ~~implementation. The P&Ps must define the scope of their enrollment process if CalOptima~~
23 ~~Health does not enroll all Provider types.~~
24
- 25 ~~b. CalOptima Health shall complete the process and provide the applicant with a written~~
26 ~~determination on CalOptima Health letterhead within one hundred twenty (120) calendar days~~
27 ~~of its receipt of a Provider application.~~
28
- 29 ~~c. CalOptima Health shall submit a list of its newly enrolled Providers every six months to~~
30 ~~CalOptima Health's DHCS Managed Care Operations Division (MCO) contract manager.~~
31
- 32 ~~d. CalOptima Health shall collect all the appropriate information, data elements, and supporting~~
33 ~~documentation required for each Provider type and ensure that the application is reviewed for~~
34 ~~both accuracy and completeness.~~
35
- 36 ~~i. CalOptima Health shall inform Providers seeking to enroll with CalOptima Health, of the~~
37 ~~differences between CalOptima Health's and DHCS' Provider enrollment processes,~~
38 ~~including the Provider's right to enroll through DHCS, at the time of application.~~
39 ~~CalOptima Health will provide required disclosures that include, but are not limited to,~~
40 ~~the following elements:~~
41
- 42 ~~a) A statement that certain enrollment functions will not be performed by CalOptima~~
43 ~~Health but will continue to be performed by DHCS, including fingerprinting, criminal~~
44 ~~background checks, and decisions to deny or terminate enrollment.~~
45
- 46 ~~b) A notice that some of the enrollment requirements and rights found in the state~~
47 ~~enrollment process may not be applicable when a Provider chooses to enroll through~~
48 ~~CalOptima Health, including provisional Provider status with Medi-Cal FFS,~~
49 ~~processing timelines of the enrollment application, and the ability to appeal~~
50 ~~CalOptima Health's decision to suspend the enrollment process.~~
51

1 A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's
2 eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and
3 make the Provider aware of the option to apply through DHCS?

4 e) ~~Medi-Cal FFS Provider enrollment process.~~

5
6 d) ~~A statement clarifying that in order for the Provider to participate in the Medi-Cal~~
7 ~~FFS program, the Provider must enroll through DHCS, and that enrolling through~~
8 ~~DHCS will also make the Provider eligible to contract with CalOptima Health.~~

9
10 ii. ~~CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS~~
11 ~~enrollment application fee amount.~~

12
13 iii. ~~CalOptima Health shall obtain the Provider's consent in order to share information~~
14 ~~relating to the Provider's application and eligibility with DHCS.~~

15
16 iv. ~~CalOptima Health shall collect and maintain the original signed Medi-Cal Provider~~
17 ~~Agreement and Network Provider Agreement for each Provider.~~

18
19 v. ~~CalOptima Health shall maintain all Provider enrollment documentation in a secure~~
20 ~~manner to ensure confidentiality of the Provider's personal information.~~

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

23
24 e. ~~Providers that apply as a partnership, corporation, governmental entity, or nonprofit~~
25 ~~organization must disclose ownership or control information as required by 42 CFR §~~
26 ~~455.104.~~

27
28 i. ~~Providers who are unincorporated sole proprietors are not required to disclose the~~
29 ~~ownership or control information.~~

30
31 ii. ~~Upon CalOptima Health's request, a Provider must submit within thirty-five (35)~~
32 ~~calendar days:~~

33
34 a) ~~Full and complete information about the ownership of any subcontractor with whom~~
35 ~~the Provider has had business transactions totaling more than twenty-five thousand~~
36 ~~dollars (\$25,000) during the twelve (12)-month period ending on the date of the~~
37 ~~request; and,~~

38
39 b) ~~Any significant business transactions between the Provider and any wholly owned~~
40 ~~supplier, or between the Provider and any subcontractor, during the five (5)-year~~
41 ~~period ending on the date of the request.~~

42
43 f. ~~CalOptima Health shall screen initial Provider applications, including applications for a new~~
44 ~~practice location, and any applications received in response to a Provider's reenrollment or~~
45 ~~revalidation request to determine the Provider's categorical risk level as limited, moderate, or~~
46 ~~high.~~

47
48 i. ~~If a Provider fits within more than one risk level, CalOptima Health must screen the~~
49 ~~Provider at the highest risk level.~~

- 1 ii. ~~A Provider's designated risk level is also affected by findings of license verification, site~~
2 ~~reviews, checks of suspended and terminated Provider lists, and criminal background~~
3 ~~checks.~~
- 4
- 5 iii. ~~CalOptima Health shall not enroll a Provider who fails to comply with the screening~~
6 ~~criteria for that Provider's assigned level of risk.~~
- 7
- 8 g. ~~Providers are subject to screening based on verification of the following requirements:~~
- 9
- 10 i. ~~Limited Risk Providers:~~
- 11
- 12 a) ~~Meet state and federal requirements;~~
- 13
- 14 b) ~~Hold a license certified for practice in the state and has no limitations from other~~
15 ~~states; and~~
- 16
- 17 c) ~~Have no suspensions or terminations on state and federal databases.~~
- 18
- 19 ii. ~~Medium Risk Providers~~
- 20
- 21 a) ~~Screening requirements of limited risk Providers; and~~
- 22
- 23 b) ~~Pre enrollment and post enrollment onsite visits to verify that the information~~
24 ~~submitted to CalOptima Health and DHCS is accurate, and to determine compliance~~
25 ~~with state and federal enrollment requirements.~~
- 26
- 27 iii. ~~High Risk Providers:~~
- 28
- 29 a) ~~Screening requirements of medium risk Providers; and~~
- 30
- 31 b) ~~Criminal background checks based in part on a set of fingerprints~~
- 32
- 33 h. ~~CalOptima Health and DHCS shall adjust the categorical risk level when any of the following~~
34 ~~circumstances occur:~~
- 35
- 36 i. ~~The state imposes a payment suspension on a Provider based on a credible allegation(s)~~
37 ~~of fraud, waste, or abuse.~~
- 38
- 39 ii. ~~The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.~~
- 40
- 41 iii. ~~The Provider has been Excluded by the Office of Inspector General or another state's~~
42 ~~Medicaid program within the previous ten (10) years, or when a state or federal~~
43 ~~moratorium on a provider type has been lifted.~~
- 44
- 45 iv. ~~The Provider would have been prevented from applying for enrollment due to a~~
46 ~~moratorium and the moratorium was lifted in the past six months.~~
- 47
- 48 i. ~~Additional criteria for high risk Providers~~
- 49
- 50 i. ~~Any person with a five percent (5%) or more direct or indirect ownership in a high risk~~
51 ~~applicant or where information discovered in the onsite or data analysis may lead to this~~
52 ~~type of request.~~

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- ii. ~~CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers 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

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9

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

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- iii. ~~When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.~~
- iv. ~~The Provider 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 Provider 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 Provider's high-risk designation and the results of the criminal background checks.~~

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j.a. Site Visits

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

1
2 iii. ~~Onsite visits may be conducted for many reasons, including, but not limited to, the~~
3 ~~following:~~

4 a) ~~The Provider was temporarily suspended from the Medi-Cal program;~~

5 b) ~~The Provider's license was previously suspended;~~

6 c) ~~There is conflicting information in the Provider's enrollment application;~~

7 d) ~~There is conflicting information in the Provider's supporting enrollment~~
8 ~~documentation; and~~

9 e) ~~As part of the Provider enrollment process, CalOptima Health receives information~~
10 ~~that raises a suspicion of fraud.~~

11
12
13 k. ~~Federal and State Database Checks~~

14 i. ~~CalOptima Health shall check the following databases to verify the identity and~~
15 ~~determine the Exclusion and/or enrollment status of all Providers:~~

16 a) ~~Social Security Administration's Death Master File;~~

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

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

19 d) ~~System for Award Management (SAM);~~

20 e) ~~CMS' Medicare Exclusion Database (MED);~~

21 f) ~~DHCS' Suspended and Ineligible Provider List;~~

22 g) ~~Restricted Provider Database (RPD); and~~

23 h) ~~CHHS Open Data Portal.~~

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

27 iii. ~~Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not~~
28 ~~participate in CalOptima Health's Provider network.~~

29 l. ~~If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for~~
30 ~~further enrollment options.~~

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

- ~~n. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider 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. Providers 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. All Providers 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.~~
- ~~q. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.~~
- ~~r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. Assembly Bill (AB) 1041
- B. California Evidence Code, §1157
- ~~B.C.~~ California Health & Safety Code §§1374.198, and 1380.2.
- ~~C.D.~~ CalOptima Health Contract for Health Care Services
- ~~D.E.~~ CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
- ~~E.F.~~ CalOptima Health Contract with Covered California
- ~~F.G.~~ CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- ~~G.H.~~ CalOptima Health PACE Program Agreement
- ~~H.I.~~ CalOptima Health Policy ~~GG.1355: CalAIM Community Supports~~ CC.1202: CalOptima Health Covered Provider Complaint
- ~~I.J.~~ CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
- ~~J.K.~~ CalOptima Health Policy GG.1607: Monitoring Adverse Actions
- ~~K.L.~~ CalOptima Health Policy GG.1608: Full Scope Site Reviews
- ~~L.M.~~ CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
- ~~M.N.~~ CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
- ~~N.O.~~ CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
- ~~O.P.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
- ~~P.Q.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
- ~~M.R.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)

~~M.S.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)

~~V.T.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)

~~W.U.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)

~~X.V.~~ Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification

~~Y.W.~~ National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers

~~Z.X.~~ Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431

~~AA.Y.~~ Title 42, United States Code, §1320a-7(a)

~~BB.Z.~~ Title 45, Code of Federal Regulations, Part 455

~~CC.AA.~~ Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
04/02/2026	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
<u>Revised</u>		<u>GG.1651</u>	<u>Assessment and Reassessment of Organizational Providers</u>	<u>Covered California</u> <u>Medi-Cal</u> <u>OneCare</u> <u>PACE</u>

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IX. GLOSSARY

Term	Definition
Appeal	<u>Covered California</u>: 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 required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. <u>Medi-Cal</u>: 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). <u>OneCare</u>: 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. <u>PACE</u>: 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 § 460.122.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Term	Definition
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Covered California: <i>Effective 01/01/2027 for CalOptima Health</i>	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	<u>Covered California</u>: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. <u>Medi-Cal</u>: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. <u>OneCare</u>: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. <u>PACE</u>: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee (CPRC)	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	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.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
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.
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	<u>Covered California</u> : An item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting and includes: Mobility devices, including walkers and manual and power wheelchairs and scooters; augmented communications devices, such as speech generating devices, communications boards, and apps; continuous positive

Term	Definition
	airway pressure (CPAP) machines; portable oxygen; hospital beds; for diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices); infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other Drugs); standard curved handle or quad canes and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pads for a mattress; nebulizers and supplies; peak flow meters; IV pole; tracheostomy tube and supplies; enteral pumps and supplies; bone stimulators; cervical traction (over door); phototherapy blankets for treatment of jaundice in newborns; lactation supplies (one breast pump and the necessary supplies to operate it as prescribed by a doctor for each pregnancy at no cost); and dialysis care equipment for home hemodialysis and home peritoneal dialysis as described in “dialysis care.” This definition does not cover neuromodulators; comfort, convenience, or luxury equipment or features; or repair or replacement of equipment due to loss or misuse. <u>Medi-Cal</u>: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. <u>OneCare</u>: Medical equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	<u>Covered California</u>: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member’s complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member’s representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but 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. <u>Medi-Cal</u>: 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

Term	Definition
	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. <u>OneCare</u>: 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. <u>PACE</u>: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, 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.
Member	An individual enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Term	Definition
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. <u>Medi-Cal</u>: 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. <u>OneCare</u>: Any Medicare Provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician Provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.



Policy: GG.1651
Title: **Assessment and Reassessment of Organizational Providers**
Department: Quality Improvement
Section: Not Applicable

CEO Approval: /s/

Effective Date: 06/01/2017

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

- A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.
- B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:
 1. The delegation shall 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 the 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 policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

- 1 C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or
2 Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605:
3 Delegation and Oversight of Credentialing and Recredentialing Activities.
4
- 5 1. A Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet
6 the requirements as outlined in this policy.
7
- 8 D. The Chief Medical Officer (CMO) or Designee, or the CalOptima Health Credentialing and Peer
9 Review Committee (CPRC) shall have direct responsibility over and shall actively participate in the
10 assessment and reassessment of an OP. The initial Credentialing decision is valid for a period of three
11 (3) years.
12
- 13 E. The CPRC shall be responsible for reviewing an OP's application information and CalOptima
14 Health's findings for determining an OP's participation in CalOptima Health's Provider network,
15 consistent with DHCS, National Committee for Quality Assurance (NCQA), and Department of
16 Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS) regulations and
17 standards. No later than January 1, 2028, the CPRC shall use up-to-date Council for Affordable
18 Quality Healthcare (CAQH) credentialing forms and processes – as applicable and available – to
19 credential and recredential OPs and only request additional information from an OP to clarify and
20 confirm information provided on the applicable and available CAQH credentialing form.
21
- 22 F. CalOptima Health shall assess or reassess OPs, including, but not limited to, the following:
23
- 24 1. Acute Rehabilitation Facilities;
25
- 26 2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
27
- 28 3. Birthing Centers;
29
- 30 4. Certified Hospice Providers;
31
- 32 5. Chronic Dialysis Clinic;
33
- 34 6. Clinical/Medical Laboratory;
35
- 36 7. Community Based Adult Services (CBAS) Providers;
37
- 38 8. Community Clinic;
39
- 40 9. Dialysis (End-Stage Renal Disease) Center/Facility;
41
- 42 10. Customized/Durable Medical Equipment (DME) Providers;
43
- 44 11. Federally Qualified Health Center (FQHC);
45
- 46 12. FQHC Look-Alikes
47
- 48 13. Free Clinics;
49
- 50 14. Health Access Programs;
51
- 52 15. Home Health Agencies;

16. Hospice and Palliative Care Providers;
 17. Hospitals;
 18. Indian Health Care Providers or Facilities;
 19. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
 20. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;
 - a. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.
 21. Non-Emergency Medical Transportation;
 22. Prosthetics and Orthotics;
 23. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;
 24. Radiology Centers (Free Standing);
 25. Rehabilitation Centers/Clinics (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);
 26. Religious Non-Medical Health Care Institutions;
 27. Residential Care Facilities for the Elderly;
 28. Rural Health Clinics (RHC);
 29. Skilled Nursing Facilities/Long Term Care Facilities;
 30. Surgical Centers (Free Standing);
 31. Transplant Programs (Organ Procurement Organization);
 32. Urgent Care Centers (Free Standing); and
 33. Medical Groups
 - a. Medical groups shall prohibit employment or contracting with practitioners or OPs (or entities that employ or contract with such practitioners or OPs) that are Excluded/sanctioned from participation in Medicare or Medi-Cal or are Excluded on any other state or federal Exclusion, sanction, restriction or Preclusion list.
- G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/ Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 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, such as California Department of Public Health (CDPH).
 2. CalOptima Health may enroll Providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.
 3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.
 4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.
- H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (e.g., housing agencies, medically tailored meal programs), and certain Enhanced Care Management (ECM) Providers, are not required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:
1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;
 2. Business licensing that meets industry standards;
 3. No history of Fraud, Waste, and/or Abuse;
 4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families;
 5. Review of history of liability claims against the Provider; and
 6. Review of federal and state exclusion, sanction, and debarment sources.
- I. CalOptima Health and its Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.
1. CalOptima Health and its Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider 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 and its Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

- 1 3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to
2 terminating the Provider and shall submit a plan of action for continuity of services for review
3 and approval before the termination.
4
- 5 J. CalOptima Health and its Delegates shall require that the OP be successfully assessed prior to
6 contracting and every three (3) years thereafter, except as otherwise specified in this policy.
7
- 8 1. CalOptima Health and its Delegates shall confirm that the OP is in good standing with state and
9 federal regulatory agencies,
10
- 11 2. CalOptima Health and its Delegates shall require OPs to be reviewed and approved by an
12 accrediting body or have received an on-site quality assessment consistent with the provisions of
13 this policy if the Provider is not accredited, as applicable.
14
- 15 K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and its
16 Delegates shall confirm:
17
- 18 1. Medi-Cal participation status of the OP and
19
- 20 2. Medicare participation status for the following OPs:
21
- 22 a. Hospitals;
23
- 24 b. Home Health Agencies (HHAs);
25
- 26 c. Hospices;
27
- 28 d. Clinical Laboratories;
29
- 30 e. Skilled Nursing Facilities (SNFs);
31
- 32 f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);
33
- 34 g. Outpatient Physical Therapy and Speech Pathology Providers;
35
- 36 h. Ambulatory Surgical Centers (ASCs);
37
- 38 i. Providers of end-stage renal disease services;
39
- 40 j. Providers of outpatient diabetes self-management training;
41
- 42 k. Portable x-ray suppliers;
43
- 44 l. Rural Health Clinic (RHCs);
45
- 46 m. FQHCs; and
47
- 48 n. FQHC Look-Alikes.
49
- 50 L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima
51 Health or its Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason
52 for its decision.

- 1
2 M. No later than January 1, 2027, CalOptima and its Delegates shall make a determination regarding the
3 credentials of a Covered California OP within ninety (90) days after receiving a completed OP
4 credentialing application, including all required third-party verifications. CalOptima and its Delegates
5 shall notify an OP, if successfully approved, of the activation within ten (10) business days of
6 approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day
7 timeline shall apply only to the credentialing process and does not include contracting completion. If
8 CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the OP's credentials
9 shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:
10
11 1. The OP is subject to discipline by the licensing entity for the OP.
12
13 2. The OP has one or more adverse action reports or one or more reports of malpractice payments
14 filed with the National Practitioner Data Bank (NPDB).
15
16 3. The OP has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.
17
18 N. CalOptima and its Delegates shall make a determination regarding the credentials of a Medi-Cal,
19 OneCare or PACE OP within one hundred twenty (120) days after receiving a completed OP
20 credentialing application, including all required third-party verifications.
21
22 O. An OP shall have the right to file a complaint about the decision in accordance with CalOptima
23 Health Policies CC.1202: CalOptima Health Covered Provider Complaint, HH.1101: CalOptima
24 Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.
25
26 P. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing files, in
27 accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing.
28

29 III. PROCEDURE

30 A. OP Initial Assessment

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33 1. Upon notification of an intent to contract, CalOptima Health and its Delegates shall confirm the
34 OP is in good standing with state and/or federal regulatory agencies based on an examination of
35 the sources listed in Section III.A.2. of this policy.
36
37 2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along
38 with the following supplemental documentation:
39
40 a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable,
41 as part of the application;
42
43 b. OPs shall ensure that all information included in the assessment application is no more than
44 six (6) months old;
45
46 i. CalOptima Health and its Delegates shall return an incomplete application to an OP, and
47 such incomplete application will not be processed until the OP submits all the required
48 information.
49
50 ii. CalOptima Health and its Delegates shall notify the Covered California OP within ten
51 (10) business days to verify receipt and inform the applicant whether the application is
52 complete.

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- iii. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare or PACE OP within thirty (30) calendar days to verify receipt and inform the applicant whether the application is complete.
 - iv. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the OP application withdrawn and will close the Credentialing file, if applicable.
 - v. If an OP application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.
 - c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (and/or business tax certificate), as applicable.
 - d. Accreditation and/or government-issued certification from the following entities, as applicable:
 - i. The Joint Commission (TJC) certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;
 - ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;
 - iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment (DME), prosthetics and orthotics supplies, and opioid treatment programs;
 - iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;
 - v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;
 - vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;
 - vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);
 - viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;
 - ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;
 - x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

- 1 xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging
2 Providers, and procedure-based modalities;
3
4 xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;
5
6 xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state
7 renal disease facilities; and
8
9 xiv. The CDPH for hospitals, ambulatory surgery centers, home health agencies, hospices,
10 dialysis centers, Community Based Adult Services centers, skilled nursing facilities,
11 Federal Qualified Health Centers verifications.
12
13 e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with
14 criteria for each type of Provider used for the assessment, and the process for ensuring that
15 the Providers credential their Practitioners;
16
17 i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.
18
19 a) The CMS or state quality review must be no more than three (3) years old. If the
20 review is older than three (3) years, then CalOptima Health shall conduct its own
21 onsite quality review.
22
23 ii. If a Provider has satellite facilities that follow the same policies and procedures as the
24 Provider, the site visits may be limited to a main facility.
25
26 f. Certificate of current professional liability insurance of at least the minimum amounts
27 required by provider type per the Contract for Health Care Services, as applicable;
28
29 g. No history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare,
30 Medi-Cal, or in federal or state health care programs, as applicable;
31
32 h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;
33
34 i. Active panels with the California Children's Services Program, if applicable;
35
36 j. Staff roster and copy of all staff certifications, or licensure, if applicable;
37
38 k. A valid Type 2 National Provider Identifier (NPI) number; and
39
40 l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement
41 Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA
42 identification number.
43
44 3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for
45 community clinics and free-standing urgent care centers in providing services to Members in
46 CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608:
47 Full Scope Site Reviews to incorporate the documents to support review prior to approval
48 decisions.
49
50 4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied
51 signatures are acceptable; however, signature stamps are not acceptable.
52

- 1 5. CalOptima Health or its Delegates shall review the history of professional liability claims that
2 resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.
3

4 B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment
5

- 6 1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
7 seeking to participate in CalOptima Health's Medi-Cal program:
8
9 a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP
10 application, in accordance with Section III.A.2. of this policy.
11
12 b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities
13 for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization
14 and Transition of Members to Managed Care, or superseding APL, signed under penalty of
15 perjury attesting that the following Credentialing requirements are satisfied:
16
17 i. Completion of the CalOptima Health Provider training within the last two (2) years;
18
19 ii. A facility site audit from a state agency;
20
21 iii. No change in five percent (5%) ownership disclosure;
22
23 iv. Possession of an active CDPH license and CMS certification; and
24
25 v. In good standing as a Regional Center vendor.
26
27 c. W-9 request for taxpayer identification number and certification.
28
29 d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less
30 residents).
31
32 e. Certificate of insurance for professional and general liability of at least the minimum amounts
33 required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.
34
35 f. No history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare,
36 Medi-Cal, or in federal or state health care programs, as applicable;
37

38 C. OP Reassessment
39

- 40 1. CalOptima Health or its Delegates shall reassess an OP at least every three (3) years after initial
41 assessment. At the time of Reassessment, CalOptima Health shall:
42
43 a. Collect and/or verify, at a minimum, all of the information required for initial assessment as
44 set forth in Section III.A. of this Policy;
45
46 b. Incorporate the following data in the decision-making process:
47
48 i. Quality review activities, including but not limited to:
49
50 a) Enrollment and other information from DHCS, CMS, or another agency, as
51 applicable;
52

- 1 b) CalOptima Health quality review results, including, but not limited to, Grievances,
2 Appeals, potential quality issue cases, and compliance cases, as applicable;
3
4 c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider
5 in the Medi-Cal provider network, as applicable; and
6
7 d) Review of medical records, as applicable.
8
9 ii. Member experience, if applicable;
10
11 iii. Liability claims history, if applicable; and
12
13 iv. Compliance with the terms of the Provider's contract.
14
15 c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in
16 Section III.B. of this policy.
17
18 i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are
19 reassessed, an ICF/DD must report that change to CalOptima Health along with any
20 required documentation within ninety (90) days of when the change occurred.
21
22 2. CalOptima Health or its Delegates shall ensure that an OP has current appropriate licensure,
23 accreditation (if applicable), and insurance at all times during such OP's participation in
24 CalOptima Health.
25
26 C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or its Delegates
27 shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General
28 (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS
29 Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database.
30 CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance
31 with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.
32
33 D. Credentialing Committee
34
35 1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-
36 review process to make recommendations and decisions regarding Assessment and Reassessment.
37
38 2. CalOptima Health's CPRC shall make recommendations and decisions regarding an OP's
39 eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or
40 Program of All-Inclusive Care for the Elderly.
41
42 3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for
43 signature, or will be presented at CPRC for review and approval.
44
45 a. A clean file consists of a complete signed application, required supporting documents that are
46 current and valid, and verification that there have been no more than one (1) malpractice
47 claim) that resulted in a settlement or judgment greater than twenty-five thousand dollars
48 (\$25,000) paid by, or on behalf of, the OP within the last seven (7) years from the date of the
49 assessment, or NPDB query identifying investigations or other actions, and confirmation that
50 the OP is in good standing with state and federal regulatory agencies.
51

- 1 i. A clean file shall be considered approved and effective on the date that the CMO or
2 Designee, reviews and approves an OP's assessment and Reassessment file, and deems
3 the file clean.
4
5 ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for
6 review and reflected in the meeting minutes.
7
8 b. Files that do not meet the clean file review process and require further review by CPRC
9 include but are not limited to those files that include a history of more than one malpractice
10 claim that resulted in settlement, or judgment of more than twenty-five thousand dollars
11 (\$25,000), paid by or on behalf of the OP.
12
13 i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the
14 application. Files that are incomplete will not be processed until the Provider submits all
15 the required information.
16
17 ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information
18 presented in the file.
19
20 iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via
21 telephone or video conferencing, but may not be conducted through e-mail.
22
23 4. OP files identified as not meeting Credentialing criteria with exceptions or potential exceptions
24 shall be referred to the CMO or Designee for review.
25
26 a. The CMO or Designee shall review each file for OPs who do not meet Credentialing criteria
27 and make recommendations regarding approving or denying Credentialing of the Provider to
28 the CPRC. For OP files not meeting criteria on an administrative basis only, the file may be
29 approved or denied by the CMO or Designee.
30
31 5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health
32 programs based on the information reviewed as specified in this policy.
33
34 a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a
35 decision letter within thirty (30) calendar days of the decision indicating:
36
37 i. Acceptance;
38
39 ii. Acceptance for less than three (3) years;
40
41 iii. Acceptance with specific conditions, which shall not be defined as restrictions and are not
42 reportable to the NPDB and/or under 805 or 805.1 requirements; or
43
44 iv. Denial of the application, along with information regarding the right to file a complaint,
45 with a letter of explanation forwarded to the applicant.
46
47 b. CalOptima Health shall activate the Covered California OP upon successful approval if the
48 approval occurs prior to the end of the ninety (90)-day timeline from receipt of a completed
49 application.
50
51 6. Upon acceptance of the participation application, the CalOptima Health Quality Improvement
52 Department shall generate a Provider profile and forward the Provider profile to the Contracting,

Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.
2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider screening and enrollment process does not need to be completed by CalOptima Health.
3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, CalOptima Health does not complete screening and enrollment established by CalOptima Health. If CalOptima Health chooses to complete DHCS screening and enrollment, this policy will be updated to reflect the required process(es).

a. Site Visits

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. Assembly Bill (AB) 1041
- B. California Evidence Code, §1157
- C. California Health & Safety Code §§1374.198, and 1380.2.
- 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 Covered California
- G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- H. CalOptima Health PACE Program Agreement
- I. CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint
- J. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
- K. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
- L. CalOptima Health Policy GG.1608: Full Scope Site Reviews
- M. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
- N. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
- O. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
- P. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
- Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)

- R. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
- S. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
- T. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
- U. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
- V. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
- W. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers
- X. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
- Y. Title 42, United States Code, §1320a-7(a)
- Z. Title 45, Code of Federal Regulations, Part 455
- AA. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
04/02/2026	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised		GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

For October QAC Review Only

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2
3

IX. GLOSSARY

Term	Definition
Appeal	<u>Covered California</u>: 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 required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. <u>Medi-Cal</u>: 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). <u>OneCare</u>: 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. <u>PACE</u>: 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 § 460.122.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Term	Definition
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Covered California: <i>Effective 01/01/2027 for CalOptima Health</i>	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	<u>Covered California</u>: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. <u>Medi-Cal</u>: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. <u>OneCare</u>: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. <u>PACE</u>: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee (CPRC)	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	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.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
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.
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	<u>Covered California</u> : An item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting and includes: Mobility devices, including walkers and manual and power wheelchairs and scooters; augmented communications devices, such as speech generating devices, communications boards, and apps; continuous positive

Term	Definition
	airway pressure (CPAP) machines; portable oxygen; hospital beds; for diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices); infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other Drugs); standard curved handle or quad canes and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pads for a mattress; nebulizers and supplies; peak flow meters; IV pole; tracheostomy tube and supplies; enteral pumps and supplies; bone stimulators; cervical traction (over door); phototherapy blankets for treatment of jaundice in newborns; lactation supplies (one breast pump and the necessary supplies to operate it as prescribed by a doctor for each pregnancy at no cost); and dialysis care equipment for home hemodialysis and home peritoneal dialysis as described in “dialysis care.” This definition does not cover neuromodulators; comfort, convenience, or luxury equipment or features; or repair or replacement of equipment due to loss or misuse. <u>Medi-Cal</u>: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. <u>OneCare</u>: Medical equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	<u>Covered California</u>: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member’s complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member’s representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but 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. <u>Medi-Cal</u>: 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

Term	Definition
	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. <u>OneCare</u>: 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. <u>PACE</u>: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, 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.
Member	An individual enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Term	Definition
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. <u>Medi-Cal</u>: 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. <u>OneCare</u>: Any Medicare Provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician Provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.



**CalOptima
Health**

Quality Policy Updates

Quality Assurance Committee

October 15, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

New Policy GG.1640: Health Network Pay for Value Program

- Defines requirements and processes for Pay for Value (P4V) program, ensuring alignment with DHCS APL – 24-004¹ and federal regulations, to improve health outcomes and promote health equity
- CalOptima Health shall implement P4V programs for Medi-Cal, OneCare, and Covered California Health Networks and primary care providers for each measurement year (MY), utilizing the Integrated Healthcare Association (IHA) scoring methodology

1. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-004: Quality Improvement and Health Equity Transformation Requirements

New Policy GG.1640: Health Network Pay for Value (PV4) Program Continued

- Establishes the incentives based on performance attainment and year-over-year improvement scores, with corrective actions required for underperformance
- Unearned incentive dollars will be redirected to quality improvement initiatives

Policy Review of GG.1611: Potential Quality Issue (PQI) Review Process

- Summary of key updates:
 - Defined investigative vs. administrative closure.
 - Clarified that PQI review is not a delegated function.
 - Clarified that immediate referral of imminent-danger cases to CMO, physician designee, or CPRC.
 - Updated outcome score table with clearer definitions and descriptions.
 - Added a 30-day target for case closure or CPRC recommendations, with an additional 30 days when supplemental records are needed.

Policy Review of GG.1611: PQI Review Process Continued

- Summary of key updates continued:
 - Required provider notification when cases escalate to CPRC, including opportunity for written clarification or discussion.
 - Clarified progressive application of corrective actions.
 - Clarified frequency and scope of reporting requirements.

Policy Review of GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues

- Summary of key updates:
 - Renamed policy to “Practitioner and Organizational Provider Corrective Action Plan of Quality Issues”
 - Expanded the range of corrective actions available to CalOptima Health.
 - Outlined the formal corrective action plan (CAP) process, including defined steps for development, submission, review, and follow-up.

Policy Review of GG.1616: Fair Hearing Plan for Licentiates

- Summary of key updates:
 - Renamed policy to “Fair Hearing Plan for Licentiates.”
 - Updated terminology to reference “licentiate” throughout.
 - Added list of practitioner types included under licentiates.
 - Defined which adverse actions do and do not trigger fair hearing rights.

Policy Review of GG.1650: Credentialing and Recredentialing of Practitioners

- Summary of key updates:
 - Removed the section permitting delegation of Medi-Cal screening and enrollment activities to delegates.
 - Expanded credentialing decision-making authority to the CMO/designee or CPRC and added a three-year credentialing approval period.
 - Expanded the practitioner types subject to credentialing and recredentialing.
 - Strengthened minimum qualification review criteria to include fraud, waste, and abuse history, criminal history, liability claims history, and exclusion/sanction/debarment review.

Policy Review of GG.1650: Credentialing and Recredentialing of Practitioners Continued

- Summary of key updates:
 - Clarified credentialing decision and notification timelines, including application expiration if no decision is made within six months.
 - Revised primary source verification and screening requirements, including additional verification elements and updated cross-references.
 - Added standardized documentation requirements for credentialing file verification.
 - Expanded practitioner rights related to review of information and status requests.

Policy Review of GG.1650: Credentialing and Recredentialing of Practitioners Continued

- Summary of key updates:
 - Revised CPRC review and decision standards, including clean-file criteria, review process, and decision notification requirements.
 - Clarified post-approval information sharing and provider directory update responsibilities.
 - Expanded required screening databases and ongoing monthly monitoring requirements.
 - Retired Attachment A, CalOptima Health Primary Source Verification Table.

Policy Review of GG.1651: Assessment and Reassessment of Organizational Providers

- Summary of key updates:
 - Clarified assessment/reassessment oversight and added a three-year initial credentialing period.
 - Expanded Medi-Cal screening criteria for providers without a state enrollment pathway.
 - Expanded adverse-action screening across Medicare, Medi-Cal, and other federal/state health care programs.
 - Applied the expanded adverse-action screening standard to ICF/DD assessments.
 - Revised clean-file criteria to add specific malpractice and NPDB thresholds.

Policy Review of GG.1651: Assessment and Reassessment of Organizational Providers Continued

- Summary of key updates:
 - Revised CPRC's role from approval to review of clean files.
 - Expanded approval outcomes, including time-limited approval and approval with conditions.



MY2025 Healthcare Effectiveness Data and Information Set (HEDIS®) Results

October 15, 2026

Linda Lee
Executive Director, Quality Improvement
Paul Jiang
Director, Quality Analytics

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Healthcare Effectiveness Data and Information Set (HEDIS)

- HEDIS is a set of standardized measures designed to provide health care purchasers and consumers with a reliable comparison of health plan performance
- HEDIS includes nearly 100 measures across six domains of care and relates to many significant public health issues, such as cancer, heart disease, smoking, asthma and diabetes
- National Committee for Quality Assurance (NCQA) uses HEDIS measures in its health plan ratings and accreditation program
- Centers for Medicare & Medicaid Services (CMS) uses HEDIS measures in the Star Rating

HEDIS and Regulatory Requirements

- California Department of Health Care Services (DHCS)
 - Managed Care Accountability Set (MCAS) — select measures must achieve a minimum performance level (MPL), which is set at the national Medicaid 50th percentile
 - Financial sanctions and corrective action plans may be imposed for measures that do not meet the MPL
 - Medi-Cal Quality Withhold- percentage of health plan capitation based on quality performance
- NCQA Health Plan Accreditation
- CMS
 - Star Ratings (OneCare)
 - D-SNP plan-level reporting

HEDIS Reporting Process

- HEDIS results are audited by NCQA-certified auditors.
 - All measures passed audit and are reportable for MY2025
 - 4 IDSS and 2 Patient Level Detail files submitted to NCQA, CMS and DHCS
- Medical records review was required for 20 measures and sub-measures with more than 3,000 charts.
 - Chart retrieval rate was 100%: at least one record was acquired for each member in hybrid sample

Medi-Cal Results Summary - MCAS

- 16 out of 18 MCAS selected measures have achieved the MPL requirement
 - Follow-up After ED visit for Alcohol and Other Drug Dependence within 30 days (FUA 31.22%) didn't meet MPL (39.1%)
 - Follow-up After ED visit for Mental Illness within 30 days (FUM 54.88%) didn't meet MPL (57.1%)

*Based on the MY2024 percentiles.

Medi-Cal Results Summary

- Health Plan Rating (HPR) — projected to increase from 3.5 to 4.0 out of 5.0 rating*
 - Projected 15 HEDIS measures receiving a higher rating than last year
 - 5 measures achieved 5.0 rating
 - 7 measures reached a 4.0 rating
 - Projected 16 HEDIS measures having the same rating as last year
 - 4 measures (SPD, SAA, ADD, PCR) may receive a lower rating
 - Projected CAHPS performance improves the rating from 2.5 to 3.0
- Quality withhold
 - Projected to earn back 100% of withhold for MY2025

*Based on the MY2024 percentiles. SPD=Statin Therapy for Patients with Diabetes, SAA=Adherence to Antipsychotic Medications for People with Schizophrenia, ADD=Follow Up Care for Children Prescribed ADHD Medications, PCR= Plan All-Cause Readmissions

Top Opportunities for Improvement: Medi-Cal

- Measures that did not meet the MPL
 - FUA and FUM (both rated 2.0 in HPR)
- Health Plan Rating measures below 3.0
 - Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB) and Pharmacotherapy for Opioid Use Disorder (POD) rated 1.0
 - Follow Up After High Intensity Care for Substance Use Disorder (FUI) and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) rated 2.0

Top Opportunities for Improvement: Medi-Cal

- Current performance within 3% of MPL margin
 - Cervical Cancer Screening (CCS-E)
 - Controlling High-Blood Pressure (CBP)
 - Glycemic Status Assessment for Patients With Diabetes - Glycemic Status >9.0% (GSD poor control)

Top Opportunities for Improvement: Medi-Cal

- Medi-Cal Quality Withhold measures that lost points or are within 3% margin
 - Well-Child Visits in the First 30 Months of Life (W30 0-15 months)
 - Well-Child Visits in the First 30 Months of Life (W30 15-30 months)
 - Removed telehealth well visits from the numerator in MY2025
 - Child and Adolescent Well-Care Visits (WCV)
 - Removed telehealth well visits from the numerator in MY2025

Top Opportunities for Improvement: Medicare

- Star measures below 3-Star cut-point*
 - BCS-E
 - Transitions of Care (TRC)
 - Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
- Star measures with x3 weight
 - CBP– (rate 78% vs 4-Star cut-point 82%*)
 - BP reading can be submitted through claims by using the CPT II code
 - Diabetes Care – Blood Sugar Controlled – (rate 88% vs 5-Star cut-point 92%*)
 - HbA1c level can be submitted through claims by using the CPT II code
 - PCR- (rate 10% vs 4-Star cut-point 9%*)

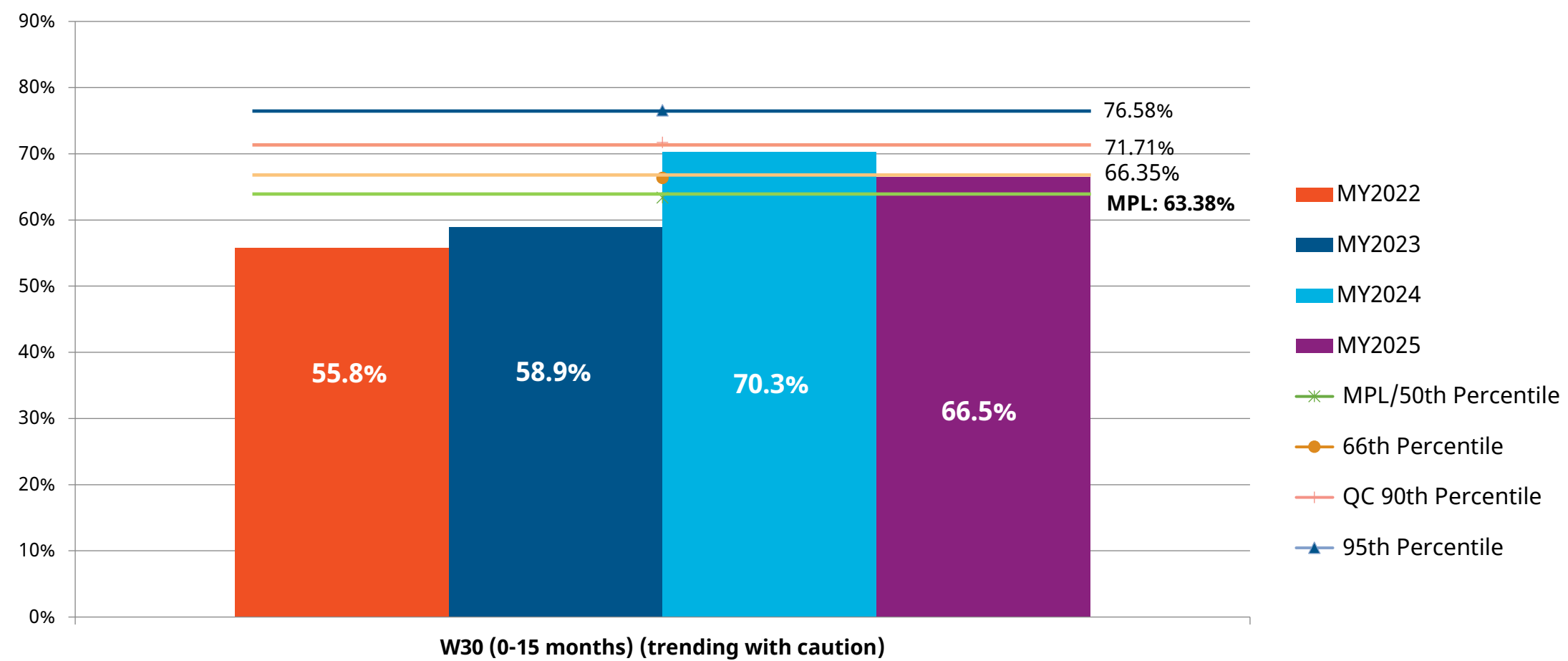
* Star Rating cut-off points are from HyperLift projected SR2027 values (Oct 2025)



Medi-Cal Priority Measure Review

HEDIS MY2025 Results: Medi-Cal

Well-Child Visits in the First 15 Months of Life (0-15)(W30)

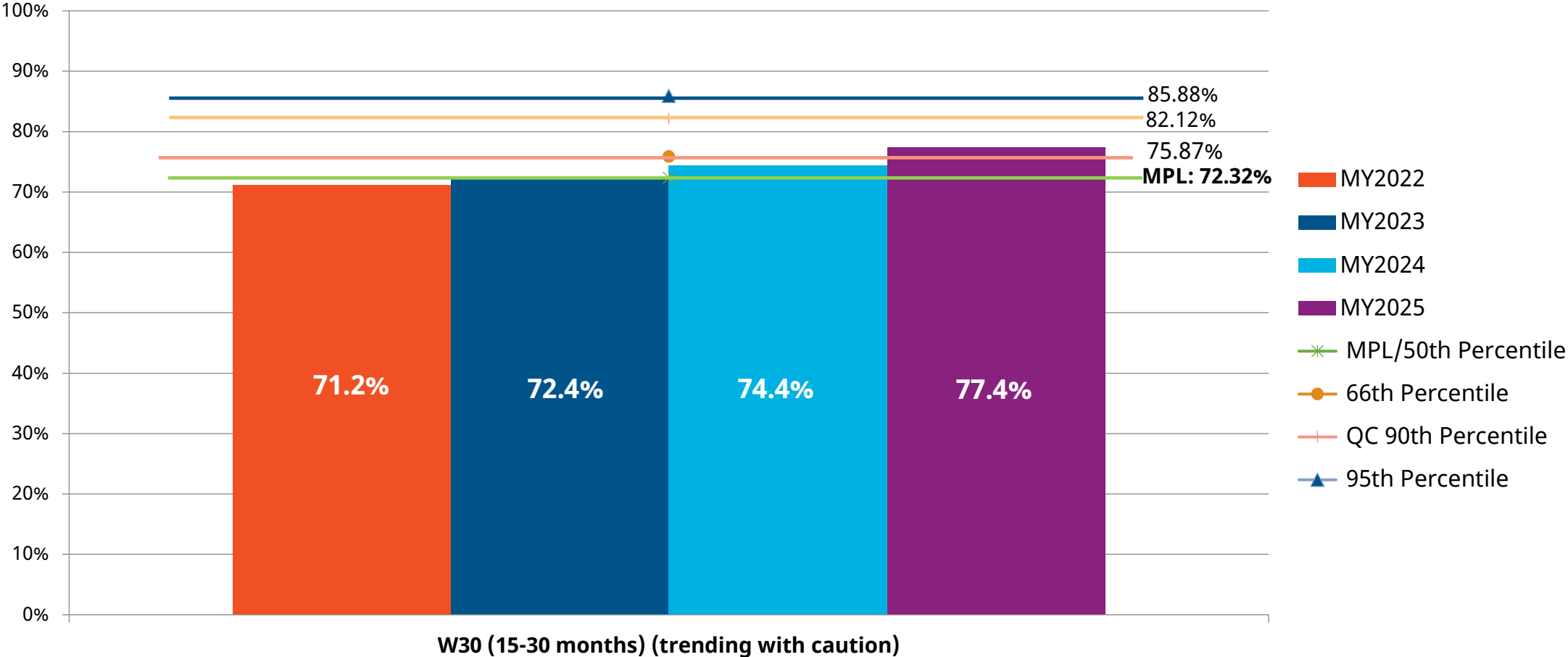


Per HEDIS 2024 Quality Compass Percentile



HEDIS MY2025 Results: Medi-Cal

Well-Child Visits in the First 30 Months of Life (15-30)(W30)

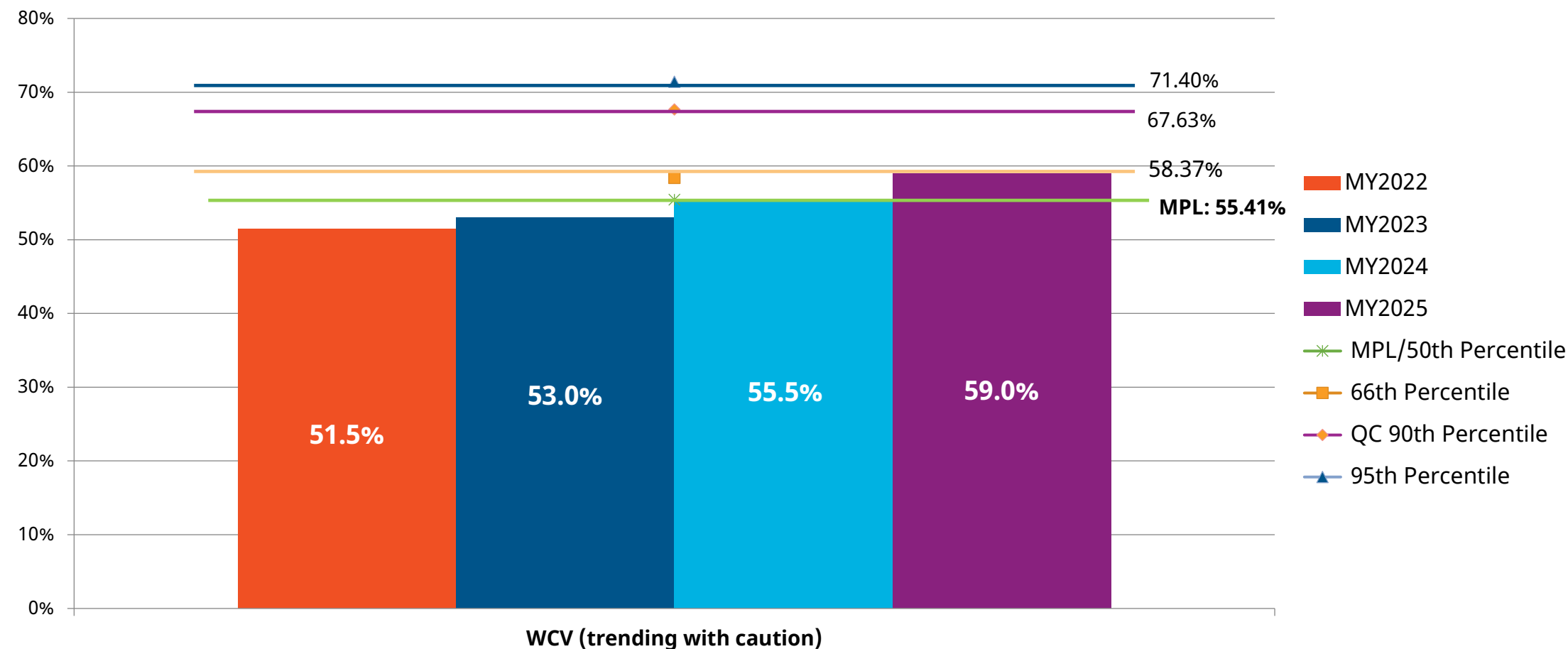


• Per HEDIS 2024 Quality Compass Percentile

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HEDIS MY2025 Results: Medi-Cal

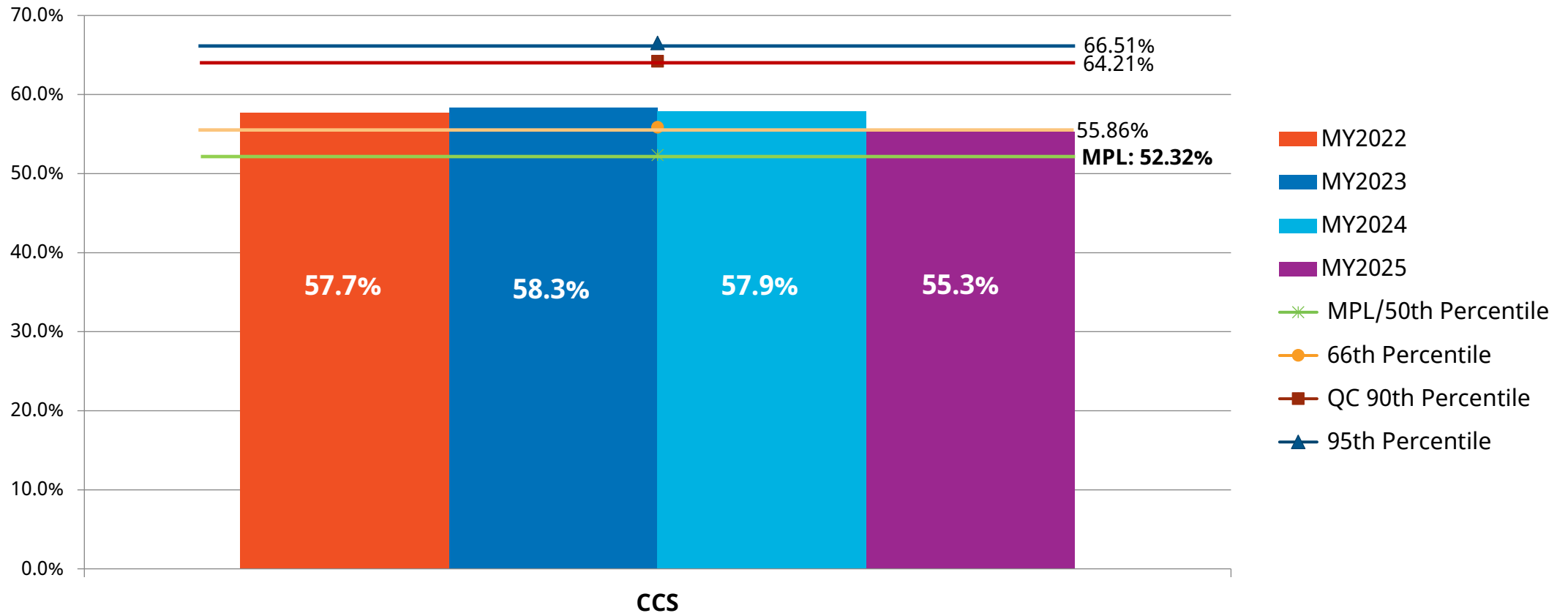
Child and Adolescent Well Care Visits – Total (WCV)



• Per HEDIS 2024 Quality Compass Percentile

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HEDIS MY2025 Results: Medi-Cal Cervical Cancer Screening (CCS)



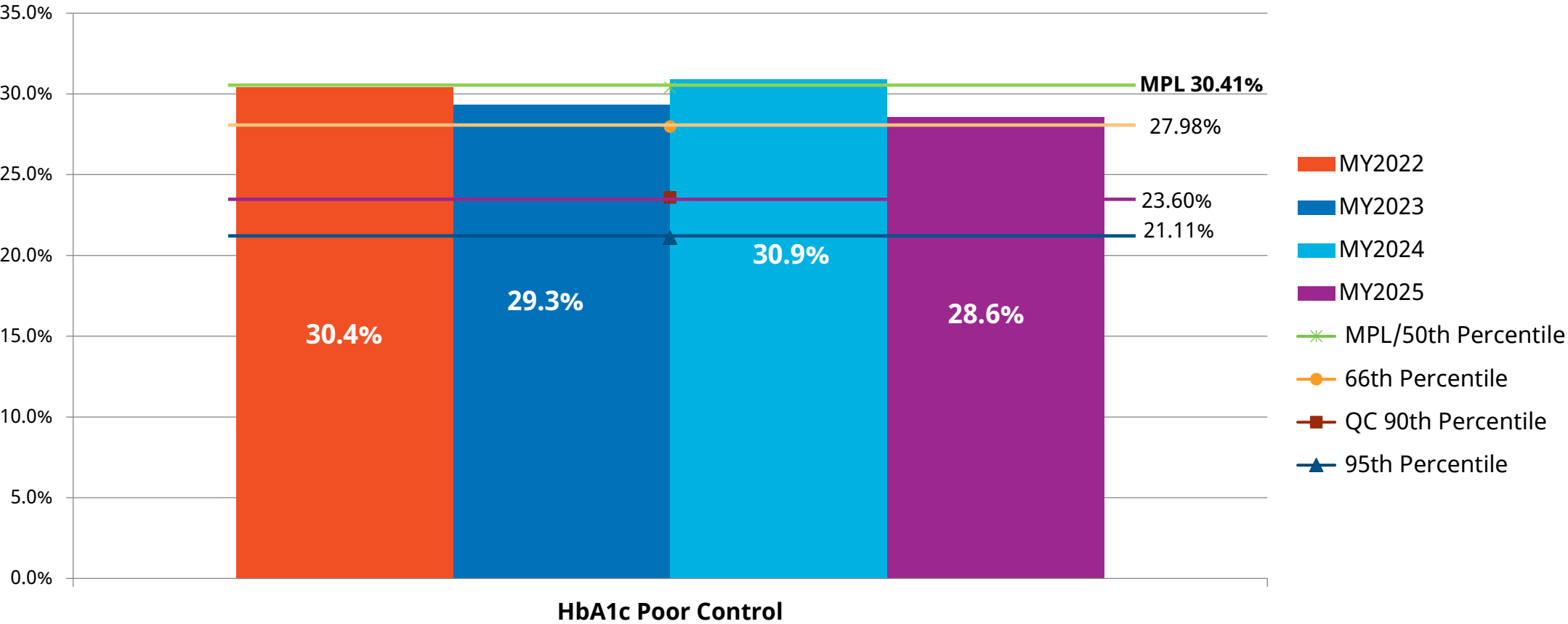
* Per HEDIS 2024 Quality Compass Percentile

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HEDIS MY2025 Results: Medi-Cal

Glycemic Status Assessment for Patients with Diabetes (GSD)

– Glycemic Status >9.0% (Lower is better)

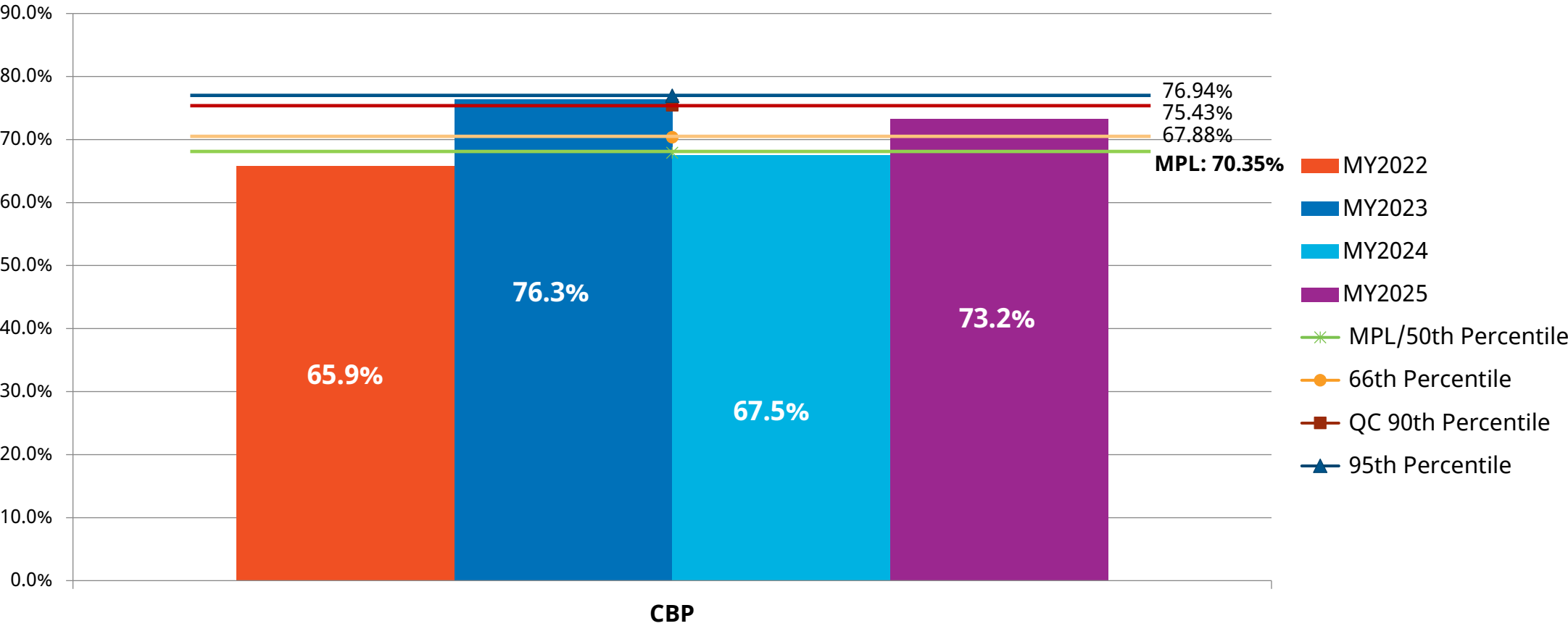


* Per HEDIS 2024 Quality Compass Percentile

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HEDIS MY2025 Results: Medi-Cal

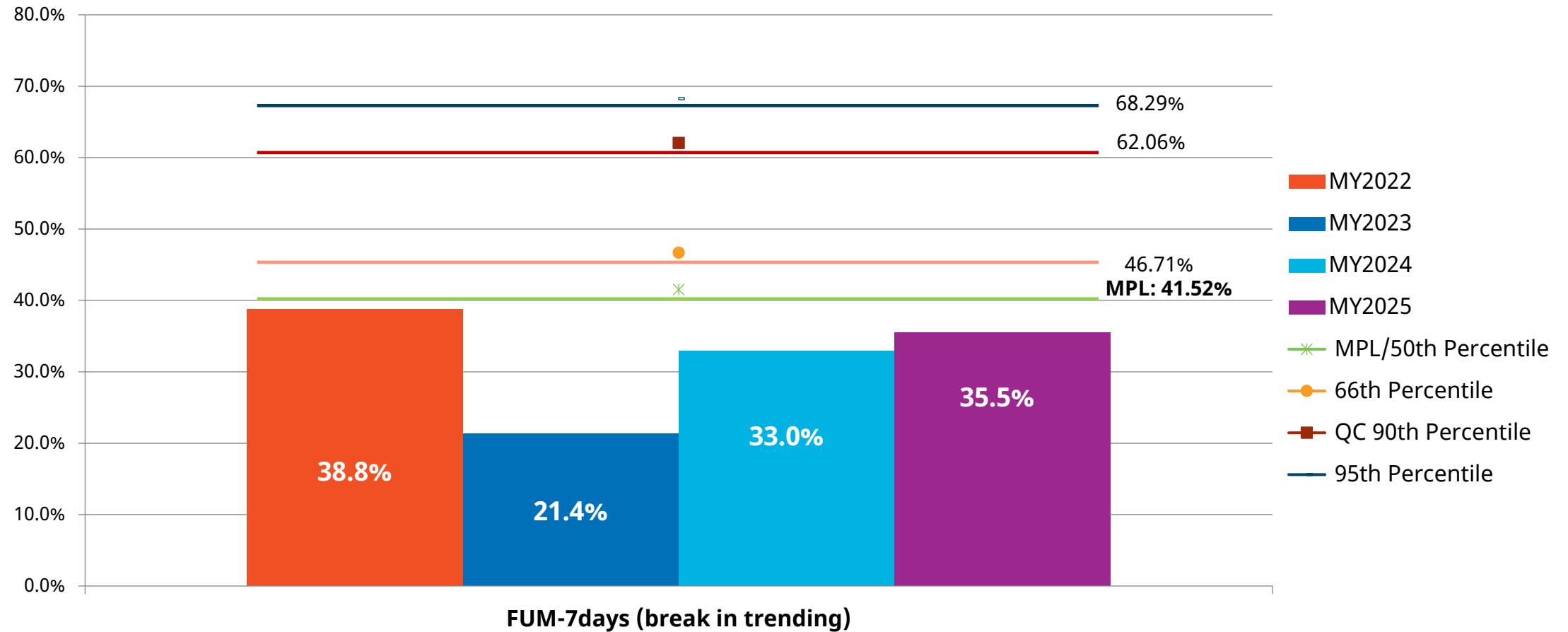
Controlling High-Blood Pressure (CBP)



* Per HEDIS 2024 Quality Compass Percentile

HEDIS MY2025 Results: Medi-Cal

Follow-Up After ED Visit for Mental Illness – 7days (FUM)

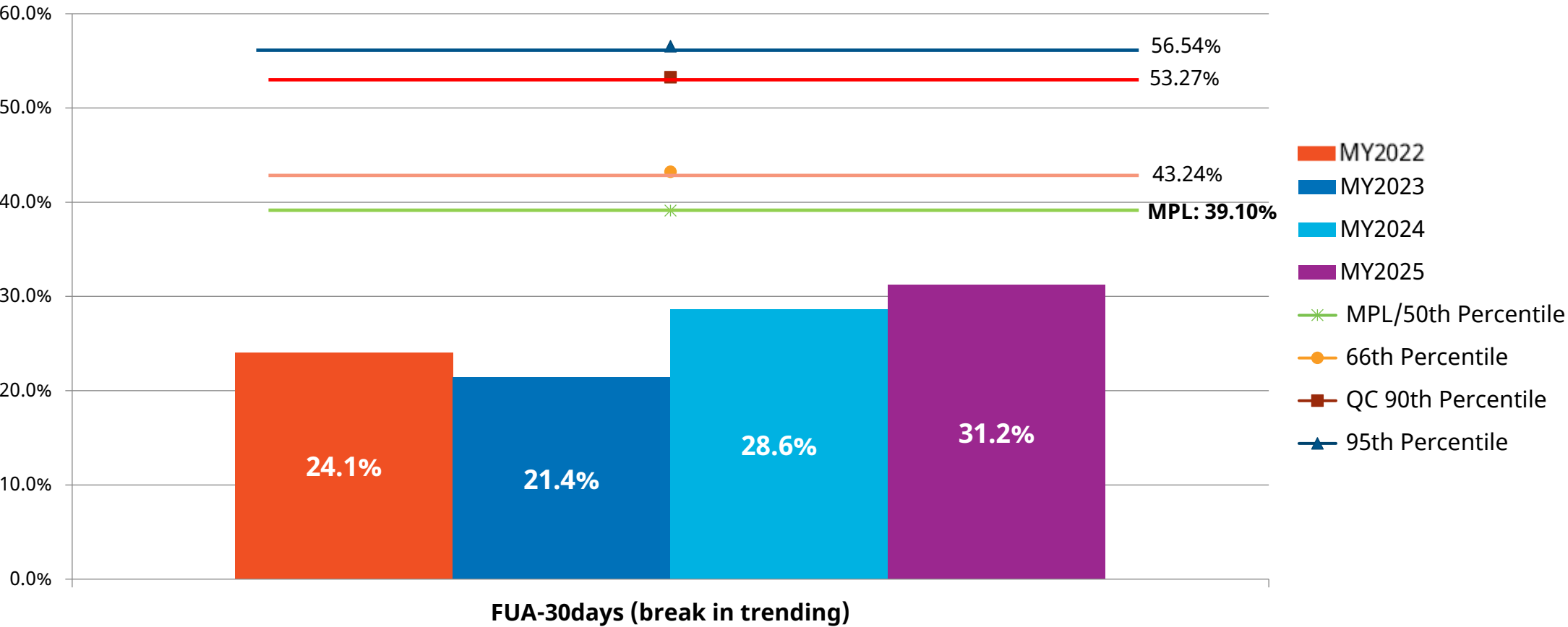


* Per HEDIS 2024 Quality Compass Percentile

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HEDIS MY2025 Results: Medi-Cal

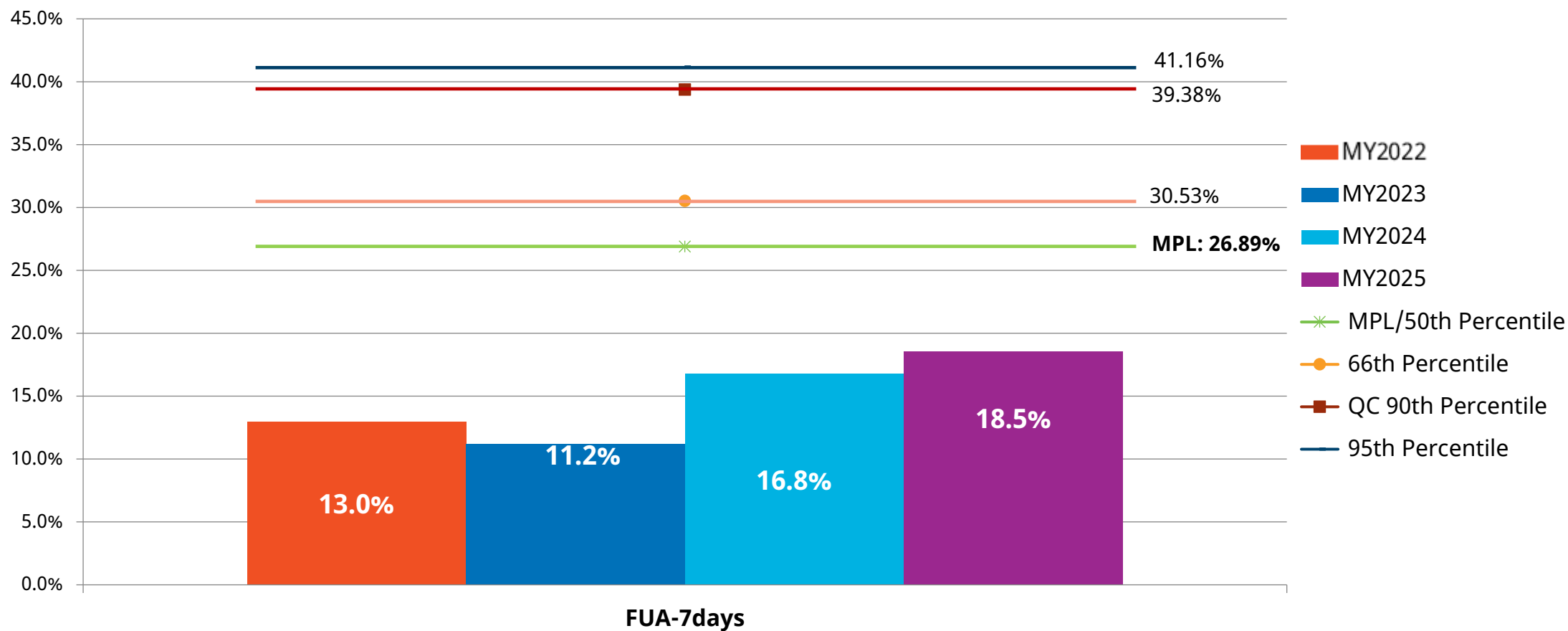
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days (FUA)



* Per HEDIS 2024 Quality Compass Percentile

HEDIS MY2025 Results: Medi-Cal

Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days (FUA)

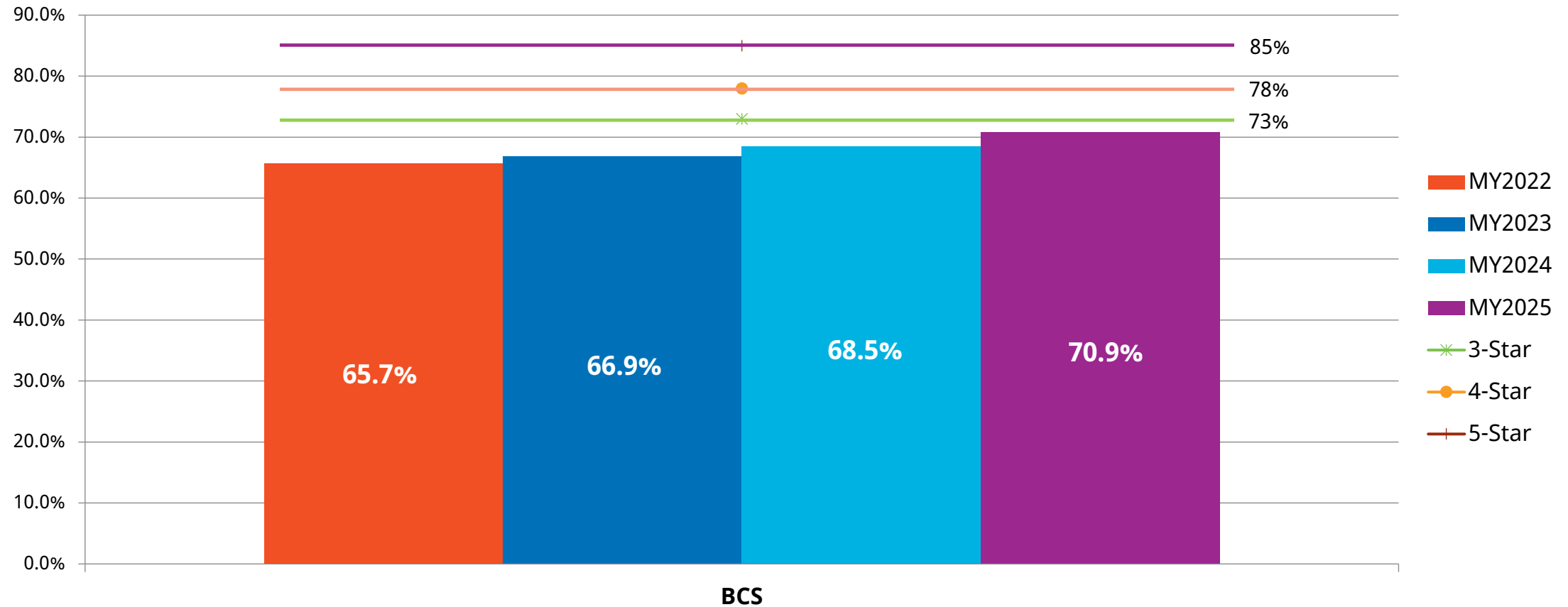


* Per HEDIS 2024 Quality Compass Percentile



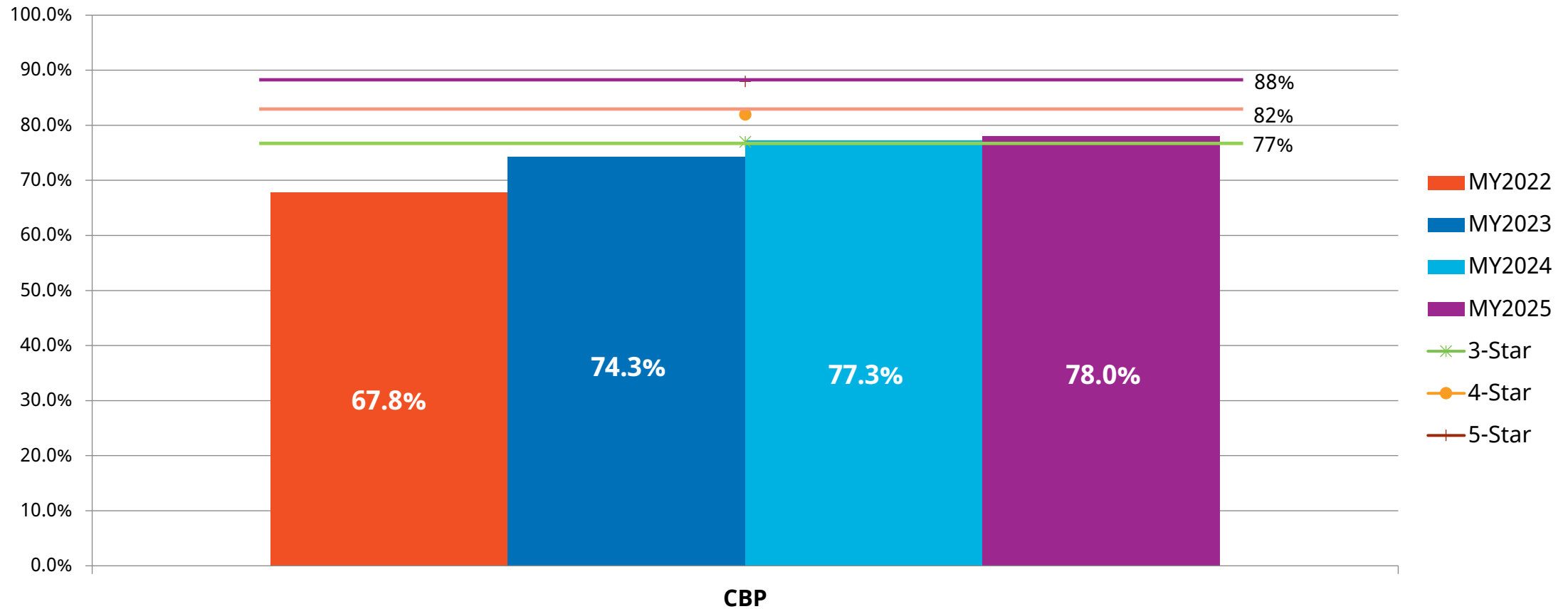
Medicare Priority Measure Review

HEDIS MY2025 Results: Medicare Breast Cancer Screening (BCS)

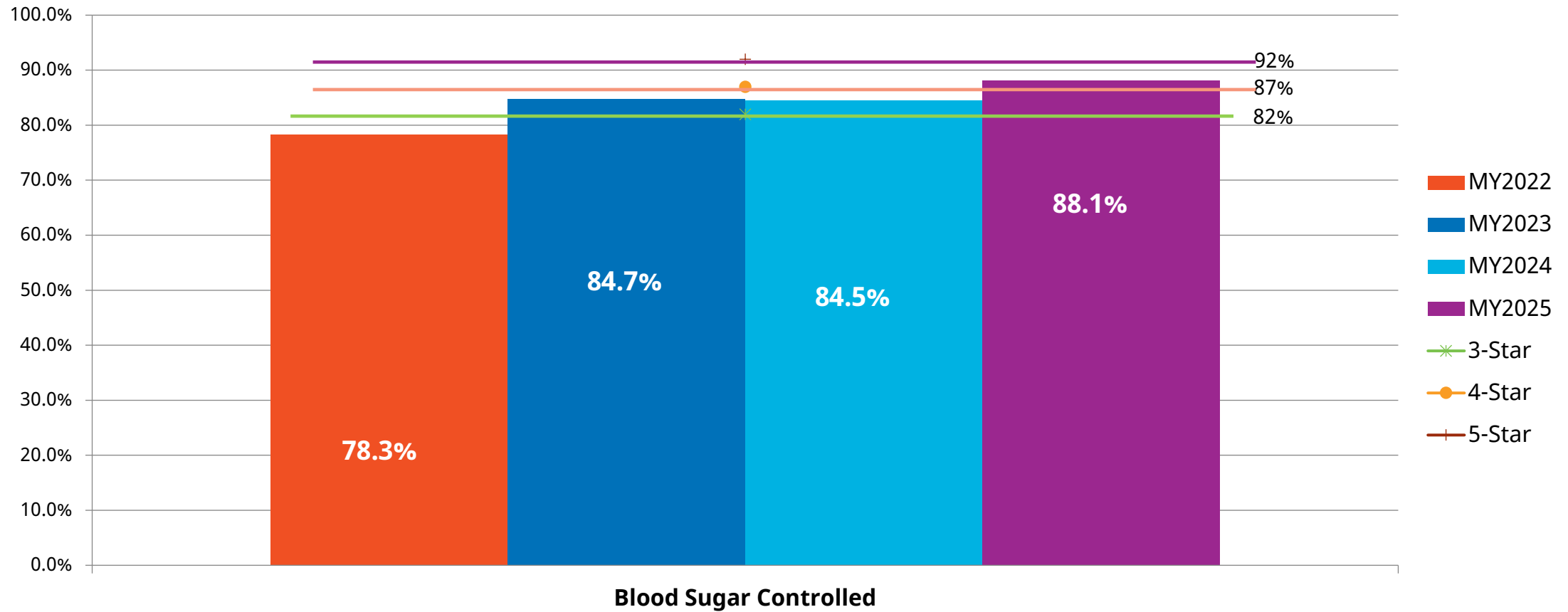


HEDIS MY2025 Results: Medicare

Control High Blood Pressure (CBP)

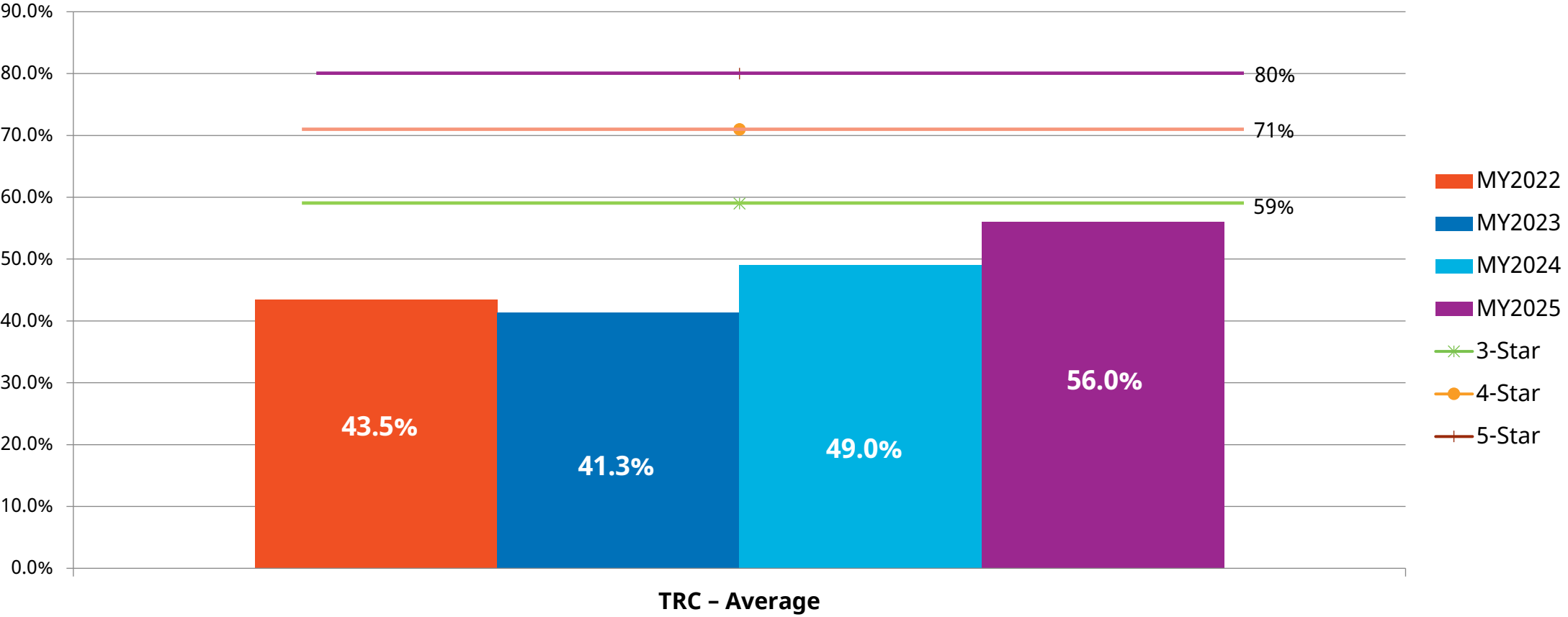


HEDIS MY2025 Results: Medicare Blood Sugar Controlled (inverted GSD>9)



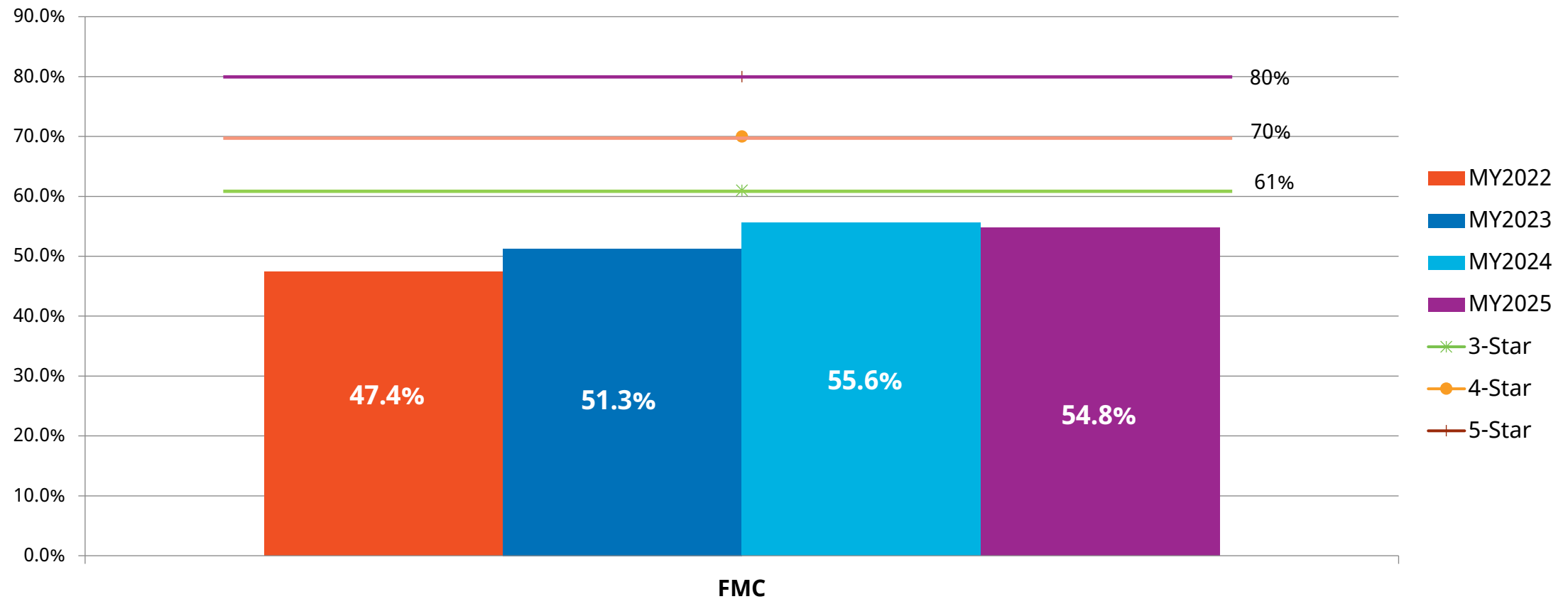
HEDIS MY2025 Results: Medicare

Transition of Care (TRC) - Average



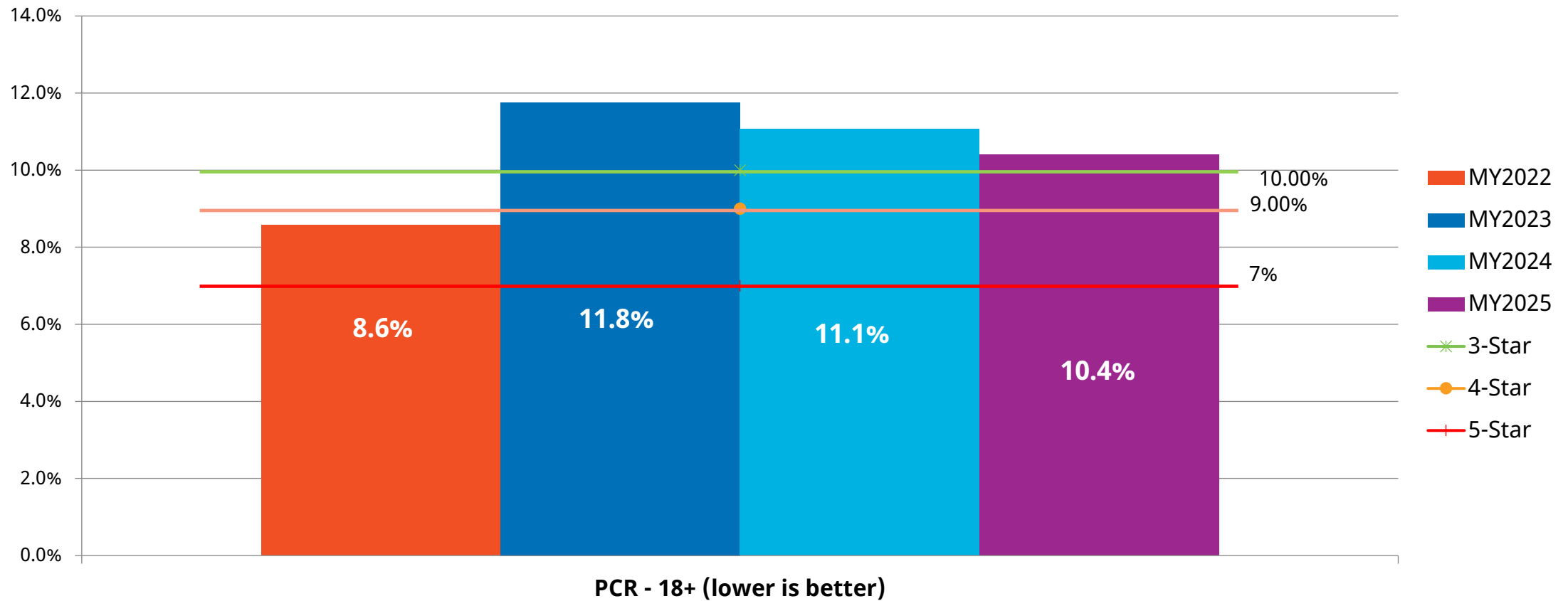
HEDIS MY2025 Results: Medicare

Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)



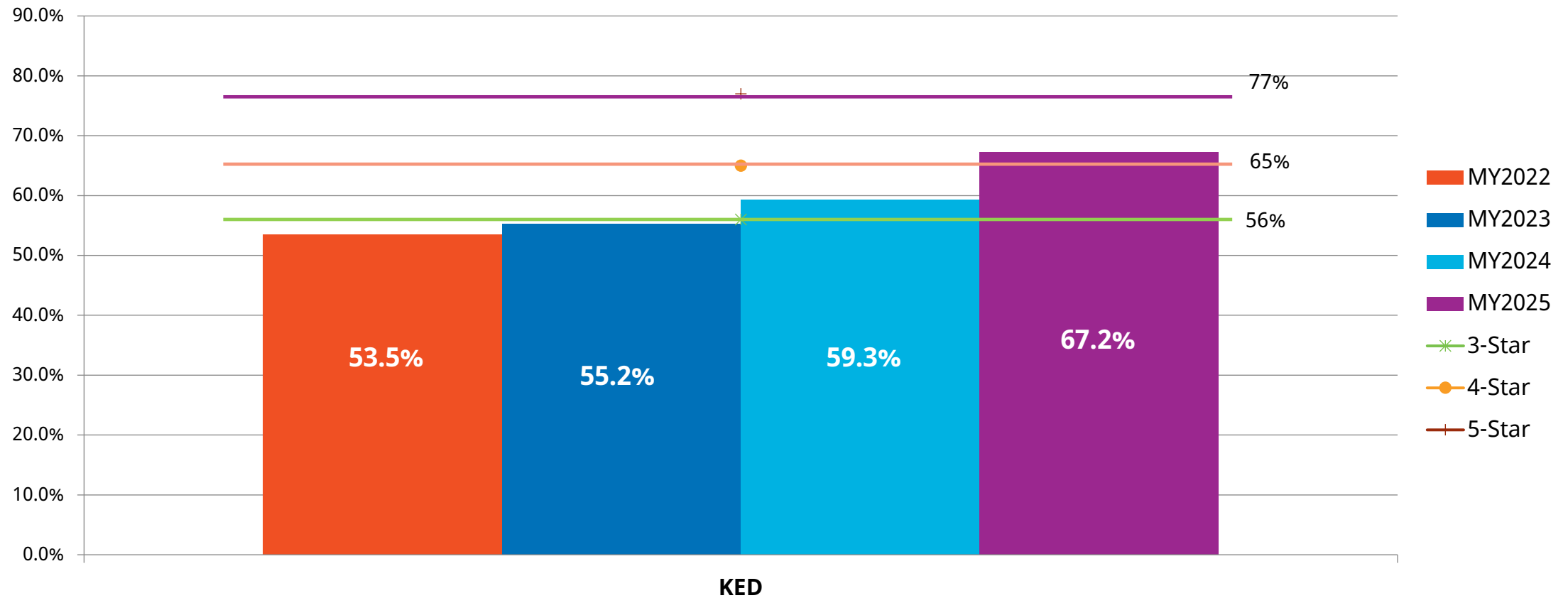
HEDIS MY2025 Results: Medicare

Plan All-Cause Readmissions (PCR) – 18+ (Lower is better)



HEDIS MY2025 Results: Medicare

Kidney Health Evaluation for Patients with Diabetes (KED)



Next Steps

- Present results to Executive Team, committees, and stakeholders
- Calculate Health Network Quality Rating Scores and P4V payments
- Prioritize and implement strategies in low-performing areas
 - Expand data sources to identify non-compliant members and providers
 - Collect medical record data for critical measures as supplemental data
- Health Plan Rating will be released by NCQA in September 2026
- Star cut-points will be released in early September 2026 during second plan preview



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CalOptima Health

Quality Improvement Health Equity Transformation Program (QIHETP) Update

Quality Assurance Committee

October 15, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.



Second Quarter 2026 Summary of the Quality Improvement Health Equity Committee (QIHEC)

QIHEC Actions in Second Quarter 2026

- QIHEC oversees the Quality Improvement Health Equity Transformation Program (QIHETP) Annual Work Plan
- In Quarter 2, 2026, QIHEC evaluated:
 - Subcommittee reports
 - CalOptima Health programs and business functions
 - Quality performance measures, including OneCare Star measures and Managed Care Accountability Set (MCAS) measures
 - National Committee for Quality Assurance (NCQA) Accreditation

QIHEC Actions in Second Quarter 2026

- QIHEC evaluated the following:
 - Quality oversight functions, including credentialing, potential quality issues (PQIs), credentialing of providers and facility site reviews (FSRs)
 - Performance Improvement Projects (PIPs)
 - Access and availability, including appointment availability and network adequacy
 - Member experience, including customer service performance, grievances and data from member experience surveys
 - Coordination of care

QIHEC Actions: Review and Approval

○ Reviewed and approved:

- QIHEC meeting minutes from March 10, 2026, April 14, 2026, and May 12, 2026
- Policy GG.1601: Quality Measure Rate Production and Data Sharing Requirements for Directed Payment Initiatives and Alternative Payment Methodology Programs
- Policy GG.1640: Health Network Pay for Value Program
- Policy GG.1639: Post-Hospital Discharge Medication Supply
- Policy GG.1205: HEDIS® Data Collection and Reporting
- Policy GG.1655: Reporting of Provider Preventable Conditions
- Policy GG.1637: Assessing Member Experience

QIHEC Actions: Program and Work Plan Oversight

- Accepted and filed the QIHETP 2026 Quarter 1 Work Plan Update and all related subcommittee minutes.
- Approved updates to the 2026 QIHETP Work Plan:
 - Refining health equity goals by adjusting targets from “exceeding the 50th percentile” to meeting the aggregate rate for the identified population.
 - Updating provider demographic data collection goals, setting targets of 18% for race/ethnicity and 7% for language reporting.
 - Adding new goals and planned activities to strengthen Quality Assurance Performance Improvement (QAPI) efforts for Long-Term Care Services



April 14, 2026 QIHEC Meeting Cont.

- CalOptima Health's Comprehensive Community Screening Program (CCCSP) completed 35,583 preventive cancer screenings in Year 1.
- Improved follow-up rates for emergency department visits related to mental health and substance use through expanded coordination with DHCS/OCHCA, telehealth vendors, and enhanced internal coordination.
- Identified low response rates in the 2025 Behavioral Health Member Experience Survey; revised engagement strategy underway for 2026.

DHCS = Department of Health Care Services
OCHCA = Orange County Health Care Agency



April 14, 2026 QIHEC Meeting Cont.

- Interpreter and translation services maintained 98% on-time completion.
- Conducted extensive health equity engagement:
 - 2 stakeholder sessions,
 - 18 internal listening sessions,
 - 23 provider trainings (1,921 attendees), and
 - maternal health training for 111 clinicians.

May 12, 2026 QIHEC Meeting

- Completed HEDIS medical record review
 - Results will be submitted to NCQA, CMS and DHCS in June 2026.
 - All MCAS measures met Minimum Performance Level (MPL) except Follow-Up After ED Visit for Alcohol or Other Drug Abuse (FUA) (31.24% vs 39.10%) and Follow-Up After Emergency Department Visit for Mental Illness (FUM) (54.86% vs 57.13%).
- In March 2026, the following measures showed improvement from the previous year:
 - Immunization for Adolescents (IMA)
 - Well Child Visits for the First 15 Months (W30)
 - Prenatal and Postpartum Care (PPC)
 - Prenatal and Postpartum Depression Screening Rates (PDS-E and PND-E)

NCQA = National Center for Quality Assurance;
CMS = Centers for Medicare & Medicaid Services
DHCS = Department of Health Care Services
MCAS = Managed Care Accountability Set

May 12, 2026 QIHEC Meeting

- Completed a Hospital Value-Based Payment Program data-sharing gap analysis.
- Enhanced member outreach efforts in Q1 2026:
 - 1,377 maternal health members received education and support from 1,129 referrals (down 27.9% from Q1 2025)
 - Postpartum 8-week text reminders to 318 recipients
 - 804 mailers for well-child appointments.
- Disease management services engaged 2,909 unique members in Q1 2026.

May 12, 2026 QIHEC Meeting

- 94.80% of OneCare members maintained an Individualized Care Plan (ICP) in the past 365 days
- In 2025, CalAIM participants demonstrated increased physician and care visits, with reduced hospital and emergency department utilization.
- Street Medicine Program expanded to Santa Ana on March 9, 2026
 - 439 members enrolled across Anaheim, Costa Mesa, Garden Grove and Santa Ana
 - 99% enrolled in CalAIM services
 - 95% engaged with a Primary Care Physician (PCP).

CalAIM = California Advancing and Innovating Medi-Cal





QIHEC Sub-Committee Reports: June 9, 2026

Subcommittee Actions in the Second Quarter of 2026: Credentialing and Peer Review Committee

- The committee met on January 29, February 26, and March 26, 2026.
- Approved three (3) policies, the credentialing clean/closure list and the potential quality issue (PQI) closure list, and track and trend reports.
- No preventable provider conditions (PPC) reported to DHCS.
- Monitored one physician on probation through the fair hearing process.
- Identified 13 providers from ongoing monitoring, resulting in suspension, probation, and termination.

Subcommittee Actions in the Second Quarter of 2026: Grievance and Appeals Resolutions Services (GARS) Committee

- The committee met on May 19, 2026
- Member grievances decreased from 5,200 in Q4 to 4,925 in Q1 2026, with a 61% reduction in repeat complainants.
- Discrimination grievances increased, from 40 in Q4 to 50 in Q1.
- Appeals declined by 70 cases, with higher overturn rates driven by new information and unresolved access gaps.

Subcommittee Actions in the Second Quarter of 2026: Member Experience Committee (MemX)

- The committee met on April 14, 2026
- Approved the 2026 MemX charter with proxy voting allowances.
- Plan-level compliance across most monitored areas except Provider to Member ratio in urology.
- Specialty gaps identified: Physical Medicine and Rehabilitation (PMR), Ear, Nose, and Throat (ENT), Obstetrics (OB), Neurology, Gastroenterology.

Subcommittee Actions in the Second Quarter of 2026: Utilization Management

- The committee met on May 21, 2026.
- Approved the following documents:
 - 2026 Clinical Practice Guidelines
 - 14 utilization management policies and procedures
 - 2026 Population Needs Assessment
- Inpatient and Prior Authorization Turnaround and times met the 95% goal for Q1 2026.
- Skilled nursing facility (SNF) pilot launched with Southern California Hospital Network (SCHN) on March 15, 2026

Subcommittee Actions in the Second Quarter of 2026: Utilization Management

- Pharmacy & Therapeutics Committee met November 20, 2025 and approved the OneCare Summary of Formulary Changes for Coverage Year 2026.
 - Added 16 drugs to formulary.
 - Removed 14 drugs from formulary.

Subcommittee Actions in the Second Quarter of 2026: Whole Child Model (WCM) Clinical Advisory Committee (CAC)

- The committee met on May 26, 2026
- Introduced the WCM Age Transition Primary Care Provider Incentive 3-Year Pilot focused on providing support during California Children's Services (CCS)/WCM transitions to adult care.
- WCM outperforms non-WCM members on most measures; key gaps appear in the 18–21 age group.
 - Continued focus needed on flu vaccination, dental access, and early immunization.
- Reviewed network adequacy data, and coverage requirements were met at the plan level.
 - AMVI Care shows gap in three specialties - allergy, immunology, and genetics.

June 9, 2026 QIHEC Meeting

- Annual delegation oversight audits identified corrective action needs for Providence Health Network and Children's Hospital of Orange County (CHOC) Health Alliance, primarily in credentialing and utilization management.



APPENDIX

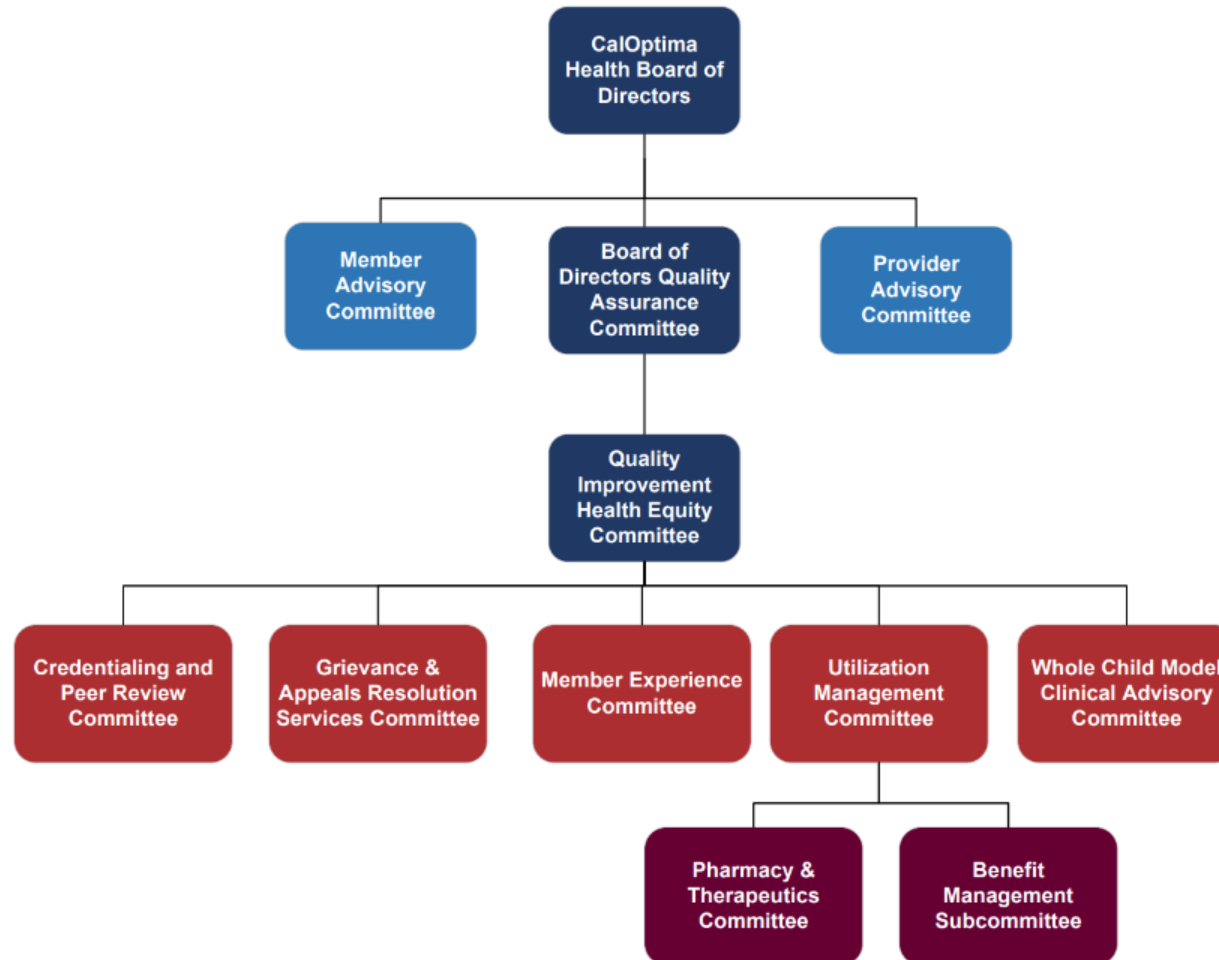
Quality Improvement Health Equity Committee (QIHEC) Purpose

- QIHEC provides overall direction for continuous quality improvement and health equity processes
- QIHEC oversees activities that are consistent with CalOptima Health's strategic goals and priorities
- QIHEC monitors compliance with regulatory and licensing requirements related to Quality Improvement and Health Equity (QIHE) projects and activities

QIHEC's Responsibilities

- Analyzes and evaluates the results of Quality Improvement and Health Equity (QIHE) activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees
- Institutes actions to address performance deficiencies, including policy recommendations; and
- Ensures appropriate follow-up of identified performance deficiencies

Quality Improvement and Health Equity Governance





National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA) Update

NCQA Health Plan Accreditation (HPA): Medi-Cal Renewal Survey

- **Completed:**

- **80% of Year One deliverables are complete**, with key focus on preparing the submission package.¹

- **In Progress:**

- Collection of **Year Two** deliverables, with primary focus on consultant validation to ensure submission readiness.²
- Coordination workstreams to engage business owners and streamline accreditation efforts.

- **Target Completion Date: April 6, 2027³**

¹ Year One: April 6, 2025 - April 6, 2026

² Year Two: April 6, 2025 - April 7, 2027

³ Scheduled submission of CalOptima Health's NCQA HPA Renewal survey (Medi-Cal).

NCQA Health Plan Accreditation (HPA): Exchange (CCA) Interim Survey

- **Completed:**

- Conducted gap assessment to identify priorities and develop an action plan.¹

- **In Progress:**

- Compiling and validating evidence needed to support delegated applicable domains.
- Finalize updates to existing policies to support NCQA HPA Interim Survey.

- **Target Completion Date:** June 15, 2027²

CCA = Covered California

¹ See the appendix for the NCQA HPA Interim Survey action plan update.

² Scheduled submission of CalOptima Health's NCQA HPA Interim survey (CCA).

NCQA HPA Interim Survey Work Plan Update: Exchange (Covered California) Product Line

Phase	Timeline	Key Activities	Milestone	Status
1: Planning	Months 1-2 (April-May 2026)	NCQA Pre-Application	03/31/2026	COMPLETE
		Purchase Interactive Review Tool	12/10/2025	COMPLETE
		NCQA Application	04/17/2026	COMPLETE
		Assemble and Launch Workstreams	04/27/2027	COMPLETE
		Initial Gap Analysis	05/29/2026	COMPLETE
		Delegation Review	05/29/2026	COMPLETE
2: Design	Months 3-5 (June-August 2026)	Develop Workplan and Action Plans	06/30/2026	COMPLETE
		Policy Revision	09/30/2026	COMPLETE
3: Validation/ Implementation	Months 6-12: (September-March 2027)	Train Staff	10/30/2026	NOT STARTED
		Execute Process Updates	10/30/2026	NOT STARTED
		Execute Program Document Updates	03/30/2027	NOT STARTED

NCQA = National Committee for Quality Assurance
HPA = Health Plan Accreditation





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Utilization Management & Clinical Operations Updates: Q2 2026

**Kelly Giardina, Executive Director, Clinical
Operations**

Dr. Robin Hatam, Medical Director

Our Mission

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Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Agenda

- Utilization Management Timeliness
- UM Program Performance: Utilization Outcomes & Sub workgroup updates
- Health Network Clinical Oversight
- Transitional Care Services
- New Clinical Initiatives



Utilization Management Turnaround Time Compliance

**Kelly Giardina, Executive Director, Clinical
Operations**

Prior Authorization Turn Around Time – Medi-Cal and OneCare

Prior authorization turnaround time compliance for prospective routine and urgent and retrospective cases remained complaint at or above 95% for the reporting period.

Prior Authorization Turnaround Time Compliance (TAT) Q3 2025 – Q2 2026 (CCN/COD)						
Year	Goal	Quarter	Month	Prospective Routine	Prospective Urgent	Retro Post Service
2025	95%	Q3	July	100.0% ▲	99.9% ▲	99.9% ▲
			Aug	99.9% ▲	99.9% ▲	100.0% ▲
			Sept	99.9% ▲	99.9% ▲	100.0% ▲
	95%	Q4	Oct	99.9% ▲	99.8% ▲	100.0% ▲
			Nov	100.0% ▲	99.9% ▲	99.8% ▲
			Dec	99.9% ▲	99.9% ▲	100.0% ▲
2026	95%	Q1	Jan	99.9% ▲	99.9% ▲	100.0% ▲
			Feb	100.0% ▲	99.9% ▲	99.9% ▲
			March	99.9% ▲	99.9% ▲	100.0% ▲
	95%	Q2	April	99.9% ▲	100.0% ▲	99.6% ▲
			May	99.9% ▲	99.9% ▲	100.0% ▲
			June	99.9% ▲	99.8% ▲	100.0% ▲

Source: Authorization Inventory Tableau Data Q3 2025 – Q2 2026.
Data pulled 7/17/2026


 Denotes comparison to goal

Inpatient Turn Around Time – Medi-Cal and OneCare

Inpatient urgent concurrent review and retro post service turnaround time remained compliant at 95% or higher throughout the reporting period except for 1 month of the reporting period.

Inpatient Turnaround Time Compliance (TAT) Q3 2025 – Q2 2026 (CCN/COD)					
Year	Goal	Quarter	Month	Concurrent Review	Retro Post Service
2025	95%	Q3	July	97.9% ▲	98.7% ▲
			Aug	99.0% ▲	100.0% ▲
			Sept	98.5% ▲	100.0% ▲
	95%	Q4	Oct	98.6% ▲	100.0% ▲
			Nov	97.8% ▲	98.3% ▲
			Dec	98.2% ▲	98.8% ▲
2026	95%	Q1	Jan	99.0% ▲	100.0% ▲
			Feb	99.3% ▲	98.6% ▲
			March	99.2% ▲	100.0% ▲
	95%	Q2	April	98.1% ▲	100.0% ▲
			May	96.6% ▲	95.2% ▲
			June	94.9% ▼	96.5% ▲

Source: Authorization Inventory Tableau Data Q3 2025-Q2 2026. Data pulled 7/17/2026

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▲ ▼ Denotes comparison to goal

Long-Term Service and Supports (LTSS)

Turn Around Time

Q3 2025 – Q2 2026

CBAS Turnaround Time (TAT) Determination Completed within 7 Calendar Days			
Year	Goal	Quarter	TAT Compliance Rate
2025	95%	Q3	100.0% ▲
	95%	Q4	100.0% ▲
2026	95%	Q1	89.6% ▼
	95%	Q2	99.8% ▲

CBAS Inquiry to Determination Completed within 30 Days			
Year	Goal	Quarter	TAT Compliance Rate
2025	95%	Q3	100.0% ▲
	95%	Q4	100.0% ▲
2026	95%	Q1	98.4% ▲
	95%	Q2	99.3% ▲

CalAIM Turnaround Time Compliance (TAT) Q3 2025 - Q2 2026				
Year	Goal	Quarter	Routine	Expedited
2025	95%	Q3	99.1% ▲	100.0% ▲
	95%	Q4	99.5% ▲	93.6% ▼
2026	95%	Q1	99.1% ▲	95.8% ▲
	95%	Q2	99.7% ▲	100.0% ▲

▲ ▼	Denotes comparison to goal
-----	----------------------------

LTSS Turn Around Time Continued

Q3 2025 – Q2 2026

New for 2026, presenting LTC by service

LTC Turnaround Time (TAT) Determination Completed within 7 Calendar Days				
Year	Goal	Quarter	LTC Service	TAT Compliance Rate
2025	95%	Q3	LTC	99.4% ▲
	95%	Q4	LTC	99.6% ▲

LTC Turnaround Time (TAT) Determination Completed within 5 Business Days					
Year	Goal	Quarter	Skilled Nursing Facility & Intermediate Care Facility Services	Subacute	ICF/DD
2026	95%	Q1	99.8% ▲	99.5% ▲	100.0% ▲
	95%	Q2	99.9% ▲	100.0% ▲	100.0% ▲

▲ ▼	Denotes comparison to goal
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**CalOptima
Health**

UM Program Performance: Utilization Outcomes & Sub- Workgroup Updates

Dr. Robin Hatam, Medical Director

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Data Trends and Findings from UMC | Utilization

Data as of Q1 2026 ,CCN/COD only; LTAC and Acute Rehab excluded, Medi-Cal excludes Duals/WCM

Metric	Medi-Cal Adult 18+		Medi-Cal Peds Non-WCM		SPD		LTC		OneCare		WCM	
	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual
Admit PTMPY	114.9	120.7 ▲	29.1	26.6 ▼	241.5	269.2 ▲	583.2	735.3 ▲	261.5	292.0 ▲	N/A	315.3
ALOS	4.3	4.6 ▲	12.2	10.6 ▼	5.7	5.4 ▼	7.8	8.1 ▲	5.5	5.5 ▼	N/A	7.7
Days PTMPY	515.9	550.4 ▲	374.7	283.1 ▼	1,438.7	1,439.7 ▲	4,501.1	5,923.7 ▲	1,520.3	1,611.▲	N/A	2,421.4
Readmit %	16.4%	18.7%▲	2.2%	2.7% ▲	21.6%	22.9%▲	23.3%	44.7%▲	14.6%	16.5%▲	N/A	8.6%
ER util. PTMPY	499.7	526.1 ▲	382.8	458.9 ▲	642.9	713.8 ▲	271.3	485.5 ▲	549.7	643.4 ▲	653.9	910.9▲
Membership (Q1)	119,062		28,328		12,367		289		3,982		1,028	

IT and analytics working on enhancements to give us more timely reporting

▲ ▼ Denotes comparison to goal

Source: [Membership and Utilization Trends dashboard](#) data as of 7/11/2026, pulled 7/17/2026



Q2 2026: Sub Workgroup Updates

Over/Under Utilization	• Focus on Home Health review opportunities • Continued monitoring high utilization of: • Skin substitutes • Lymphedema pumps • Venous and arterial procedures • Focus on Hospice utilization and post-service review
High-Risk Management	• Monitoring PHM KPIs including breakdown by Health Network • OC Urgent Care Post Discharge collaboration expanded to all discharge types • Partnering with Corner Health Urgent Care for post-discharge support
EPSDT	• Annual Audits focused on Speech Therapy, Private Duty Nursing, and denials • Implemented dashboard tracking screenings

Q2 2026: Sub Workgroup Updates

Emergency Department	• Support facilities through recuperative care bed day information • Review High ED Utilizers across all EDs • Implementing ED high-utilizer notification letters for PCPs									
Skilled Nursing Facility (SNF)	• SNF Pilot implemented with SCHN – weekly rounds • Established weekly non-SCHN and ARU Rounds • Sharing Discharge summaries with PCP									
Population Health Management (PHM)	• Preparing for implementation of DHCS Risk Stratification Tool • Monitoring performance for key metrics:<table><tr><th>Metric (all CalOptima Health)</th><th>Goal</th><th>Q2 2026</th></tr><tr><td>Initial Health Appointment (IHA) <i>all ages</i></td><td>40.0%</td><td>32.8% ▼</td></tr><tr><td>Initial Health Appointment (IHA) <i><18 mos.</i></td><td>40.0%</td><td>72.1% ▲</td></tr></table> ▲ ▼ Denotes comparison to goal	Metric (all CalOptima Health)	Goal	Q2 2026	Initial Health Appointment (IHA) <i>all ages</i>	40.0%	32.8% ▼	Initial Health Appointment (IHA) <i><18 mos.</i>	40.0%	72.1% ▲
Metric (all CalOptima Health)	Goal	Q2 2026								
Initial Health Appointment (IHA) <i>all ages</i>	40.0%	32.8% ▼								
Initial Health Appointment (IHA) <i><18 mos.</i>	40.0%	72.1% ▲								

Potential Quality Issues: UM

The number of Potential Quality Issues (PQI) related to authorizations has been consistent over the past 3 quarters. Of the 14 PQI in Q2 2026, 1 was leveled quality of care and 13 were leveled quality of service.

Sub-Category	Q3 2025	Q4 2025	Q1 2026	Q2 2026
Authorization denial or delayed	10	4	3	4
Authorization issues - delayed or incomplete (BH)	0	0	0	0
Authorization issues - Medical records or documentation (BH)	0	2	0	0
Delay of service	2	0	0	0
Failure to notify the member of the referral	0	1	0	0
Failure to refer	4	4	4	5
Failure to submit referral timely	3	0	6	2
Referral submitted to wrong specialist or specialty	2	0	0	3
TOTAL	21	11	13	14



Health Network Clinical Oversight

Dr. Robin Hatam, Medical Director

Health Network Clinical Oversight

- **Enhanced oversight through the Delegation Oversight performance dashboard** and a structured audit and monitoring program, resulting in improved compliance and operational performance across delegated health networks.
- **Streamlined CAP escalation processes** by formalizing internal and delegate procedures, tightening follow-up and enforcement, and accelerating CAP closure timelines.
- **Covered CA Pre-Delegation Readiness Assessments launched** in June for all CCA delegates, supported by newly developed audit tools aligned with commercial LOB regulatory requirements.



Transitional Care Services (TCS)

Kelly Giardina, Executive Director Clinical Operations

DHCS: TCS Key Performance Indicators

1. Case Management for High-Risk Members after discharge (CMHRD)

- % of high-risk transitions with at least one care manager interaction within 7 days of discharge – Includes ECM

2. Follow-Up Ambulatory Visit After Discharge (FUAH)

- % of acute discharges with a follow-up ambulatory visit within 7 days of discharge

Metric	State Average	CalOptima Health Jan 2026	CalOptima Health July 2026
CMHRD	20.7%	27.67% ▲	31.60% ▲
FUAH	42.1%	38.98% ▼	38.12% ▼

▲ ▼ Denotes comparison to state

Sources:

CalOptima Health, all Health networks (CC0271) PHM CMHRD KPI Report measure period 4/1/2025 - 3/31/2026

DHCS report date: 07/31/2026.





Update on Clinical Initiatives

Kelly Giardina, Executive Director Clinical Operations

Clinical Initiatives

- Southern California Hospitalist Network (SCHN) program pilot
- OC Urgent Care Post Discharge Support
- Provider Portal for Inpatient
- Standard Prior Authorization List
- Unsatisfactory Immigration Status (UIS) Transition

Southern California Hospitalist Network (SCHN) program

- Pilot launched March 16, 2026.
- 19 Participating skilled nursing facilities (SNF)
 - Preferred SNF list for hospital partners to refer for SNF placement
- 104 members served during Q2.
- Targeted escalations to SNF leadership with quality concerns raised during rounds.
- Post Discharge access with OC Urgent Care offered to address PCP follow-up gaps.

OC Urgent Care: Post Discharge Support Pilot

- **Purpose:**
The program bridges the gap for members unable to see their PCP within 7 days post-discharge, ensuring timely follow-up and reducing risks associated with delayed care
- **Scope:**
Available at all OC Urgent Care locations, supporting hospitals, SNFs, and EDs
- **Member Impact:**
 - 200+ members served since inception.
 - Positive member feedback, especially for weekend and evening appointment availability
- **Operational Value:**
Functions as a “gap visit,” which is crucial for continuity of care and preventing readmissions

Provider Portal Enhancement

- **Functionality:**

Hospitals can now submit admission notification clinicals and access real-time authorization status, improving workflow efficiency and care coordination

- **Training:**

Utilization Management teams are actively being trained on improved functionality to promote adoption and optimal use of the portal

- **Provider Feedback:**

Hospital Providers report positive experiences, highlighting improved visibility and streamlined access to authorization information with this enhancement.

Unsatisfactory Immigration Status (UIS) Transition to Fee-For-Service 1/1/2027

Clinical Workgroup Focus (est. 8/10/2026):

- DHCS released a UIS Policy guide to establish requirements and timelines for communications, care coordination and continuity of care.
- Analyze utilization to identify and support members transitioning to FFS who are in Care/Case Management, in active treatment or any high-risk or special populations.
- Support Health Networks to ensure transition care coordination for all members in clinical programs, with consistent communication and to promote high-touch, coordinated care.
- Report progress and updates to CalOptima Health enterprise workgroup

Standardized Prior Authorization List

- CalOptima Health Medical Management launched a review in 2025 to update and standardize protocols for Prior Authorization (PA) procedures.
- Changes support monitoring and oversight, build operational efficiencies and create equity across all CalOptima Health.
 - Initial list developed with industry expert consultants.
 - CalOptima Health Medical Directors and clinical leadership reviewed all recommended codes and Finance Department provided tools for clinical team to size the final impact for codified and standardized list to release to Health Networks.
 - The goal is to promote safe and appropriate utilization, member and provider satisfaction and a streamlined PA process.

Standardized Prior Authorization List (Continued)

- **Impact on Prior Authorization Codes as of August 2026**
 - Medi-Cal added 236 & removed 354
 - OneCare added 40 & removed 348
- **Health Network Implementation Roadmap**
 - Health Network PA List must be approved by their UMC & due to CalOptima Health on 11/23/26
 - CalOptima Health & Health Networks Implement final lists on 1/1/27
 - Publicly displayed for member & provider visibility



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**CalOptima
Health**

Member Grievances and Appeals Report Second Quarter 2026

Quality Assurance Committee Meeting

**Heather Sedillo, Grievance and Appeals Resolution
Services (GARS), Director**

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Definitions

- Grievance: An expression of dissatisfaction with any aspect of a CalOptima Health program, provider or representative.
- Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify, or discontinue a covered service.



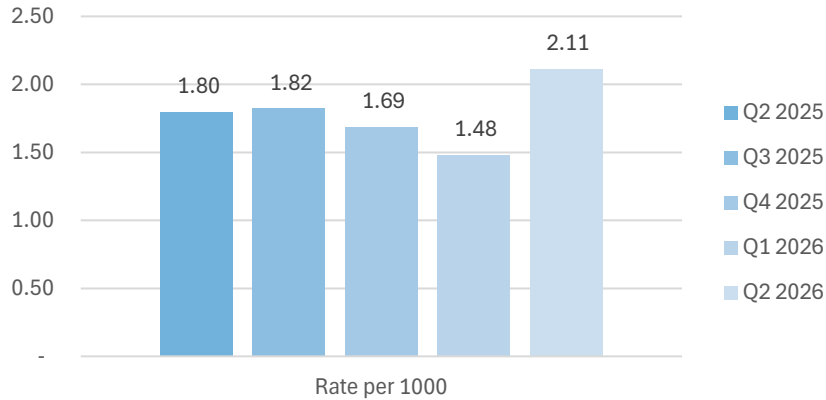
Grievances

Grievances Q2 2026 Summary

- Total grievance volume (Customer Service (CS) + GARS) increased from 4,925 in Q1 to 6,160 in Q2.
- Grievance category drivers in Q2 shifted to Provider Services/Staff, Transportation, Gift Cards and CalAIM, differing from Q1 drivers.
- CCN remained the highest-volume Health Network (HN), with top grievance drivers being Delay in Referral, Provider Services/ Staff Attitude, and Appointment Availability, differing from Q1 drivers.
- In Q2, from the members with multiple grievances presented in Q1, there was an increase of 71% of grievances submitted in Q2 from that group of members.

Grievance Volume all LOB's Q2 2025 – Q2 2026

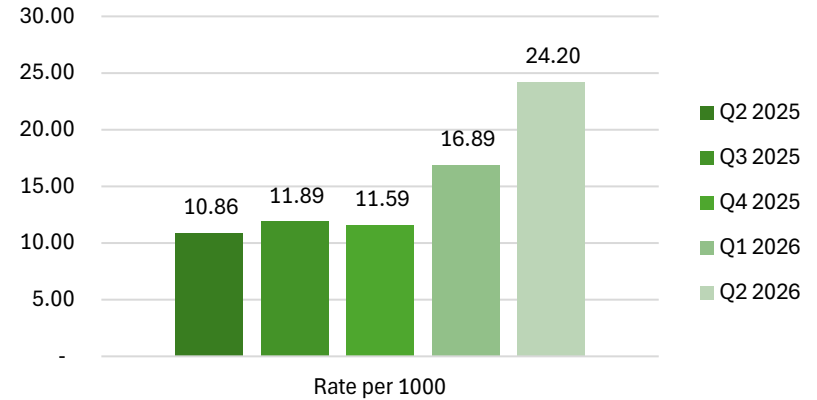
**Medi-Cal Grievances Rate per 1,000
Member Months (MM)**



Total Grievances

Timeframe	Total Grievances
Q2 2026	4,774
Q1 2026	4,023
Q4 2025	4,554
Q3 2025	4,781
Q2 2025	4,778

**OneCare Grievances Rate per 1,000
Member Months (MM)**



Total Grievances

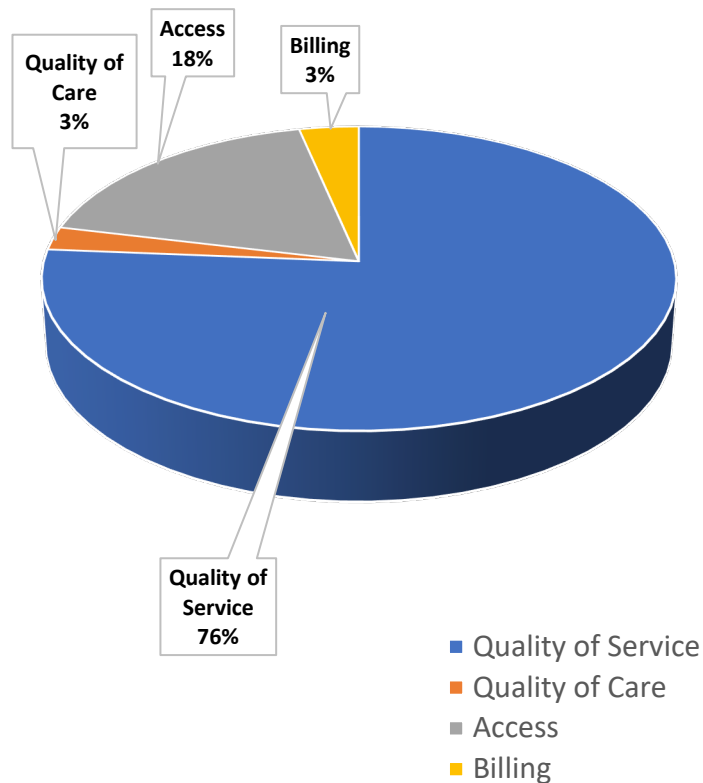
Timeframe	Total Grievances
Q2 2026	1,386
Q1 2026	977
Q4 2025	646
Q3 2025	643
Q2 2025	574

*Data includes CS exempt Grievances

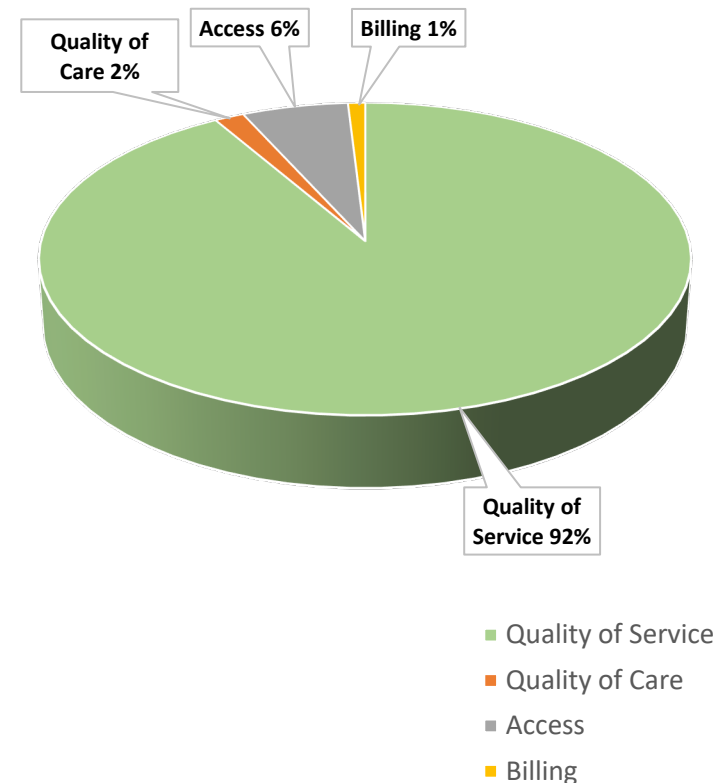
Medi-Cal and OneCare Q2 2026

Grievance Type by Category

Medi-Cal by Category



OneCare by Category



Grievance Trends for Q2 2026

Medi-Cal- Quality of Service

Trend	Percentage of Total Volume
Provider Services/Staff	51% (1,442)
Transportation Related	12% (337)
CalAIM related	8% (227)

Medi-Cal- Access

Trend	Percentage of Total Volume
Appointment Availability	21% (137)
Telephone Accessibility	10% (66)
Delay in Referral Provider	10% (66)

OneCare- Quality of Service

Trend	Percentage of Total Volume
Transportation NMT	33% (223)
Provider Services/Staff	20% (136)
Gift Card Related	8% (52)

OneCare- Access

Trend	Percentage of Total Volume
Telephone Accessibility	19% (8)
Delay in Referral by HN	14% (6)
Appointment Availability	12%(5)



Appeals

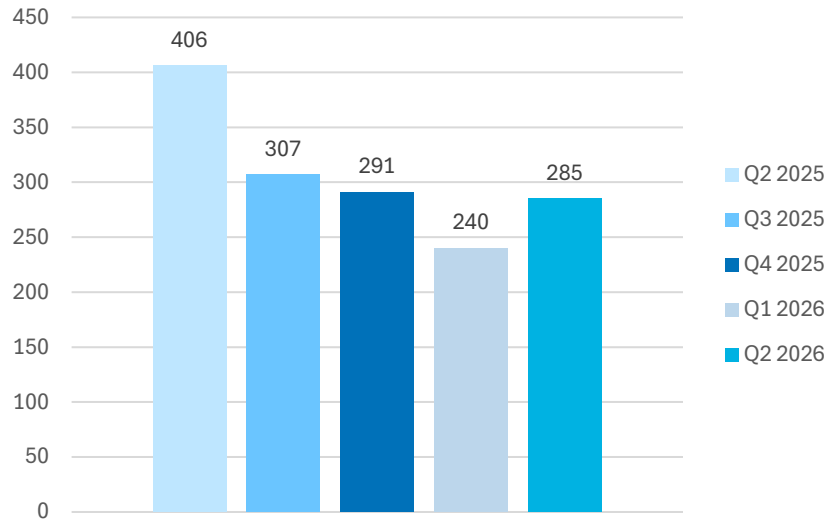
Appeals Q2 2026 Summary

- Medi-Cal and OneCare appeals volume increased by 83 from Q1 to Q2, with 100% compliance and an average turnaround time (TAT) of 24 days for case closures.
- Top overturn reasons: Criteria met based on new information received during the appeal; Community-Based Provider/INN access standards were not met; and the Tertiary Care guideline was met.
- Medi-Cal overturn rates decreased from 36% to 27%. OneCare rates increased from 43% to 49%, respectively.
- UM Provider appeals volume increased from 452 in Q1 to 612 in Q2. The overturn rate continues to decrease. Q2 overturn rate was 4%.
- External reviews (QIO, IRE, SFH) had low overturn rates, except for SNF continued-stay denial appeals (QIO). The leading reason for SNF overturns remains consistent with Q1 – insufficient discharge plan.

Appeals Volume all LOB

Q2 2025 – Q2 2026

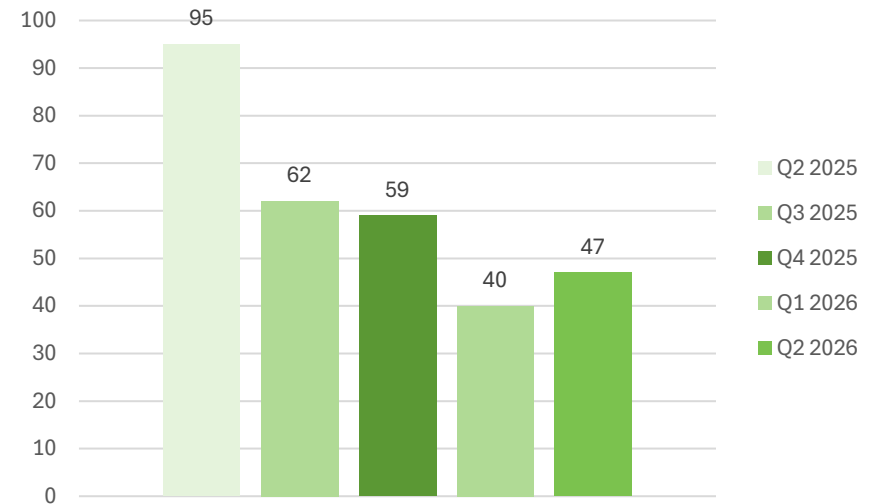
Medi-Cal



Total Appeals

Q2 2026	285
Q1 2026	240
Q4 2025	291
Q3 2025	307
Q2 2025	406

OneCare



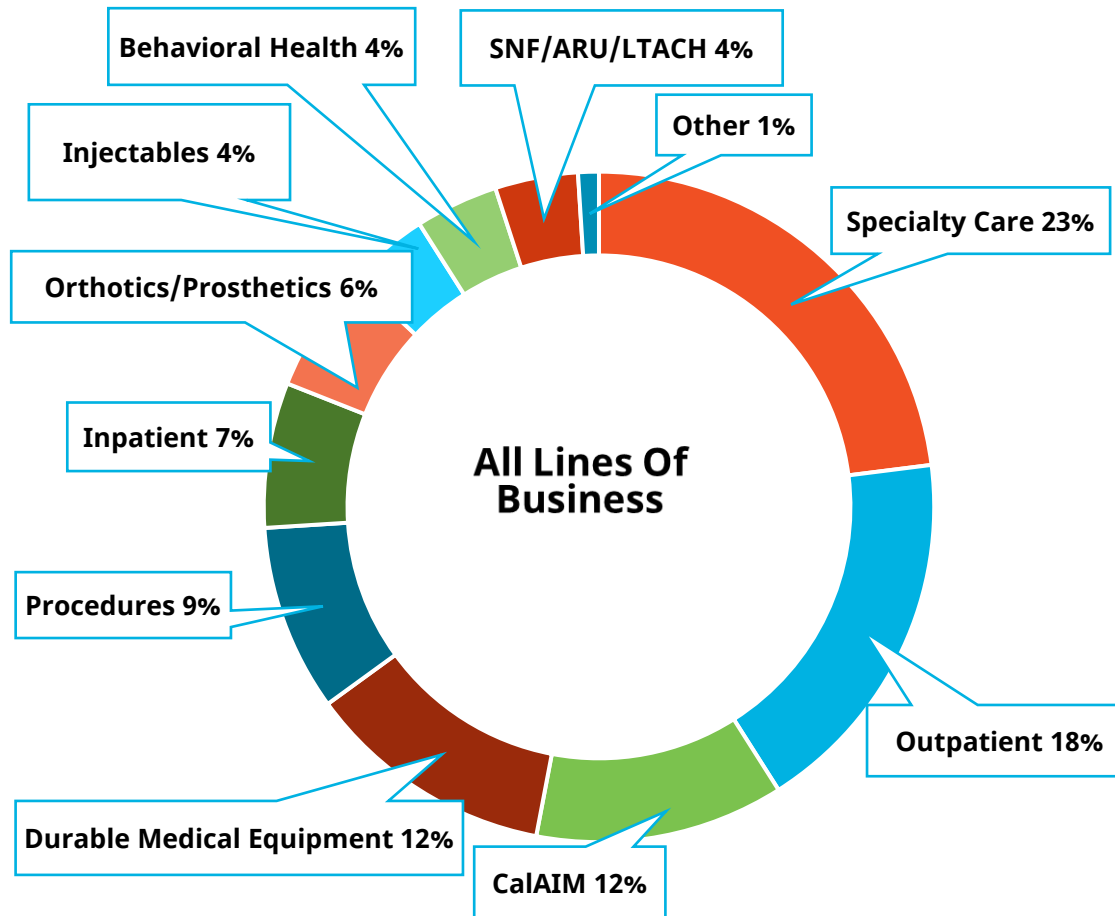
Total Appeals

Q2 2026	47
Q1 2026	40
Q4 2025	59
Q3 2025	62
Q2 2025	95

Member Appeals

All Lines of Business

Appealed Services



Services	Qty	%
Specialty Care	84	23%
Outpatient Services	66	18%
CalAIM	45	12%
DME	42	12%
Procedures	32	9%
Inpatient Services	26	7%
Orthotics/Prosthetics	20	6%
Injectables	16	4%
Behavioral Health (BH)	15	4%
Skilled Nursing/Acute Rehab/Long Term Acute Care	14	4%
Other	3	1%

Keynote: In Q2, DME and Outpatient appeals increased over 50%, while Injectable appeals decreased by 20% compared to Q1.

Q2 2026 Appeals Trends

Medi-Cal Appeals

Type	Overturn Count	Uphold Count	Total	Overturn Percentage (%)
Outpatient	58	112	170	34%
DME	10	38	48	21%
CalAIM related	1	35	36	3%

OneCare Appeals

Type	Upheld Count	Overturned Count	Total	Overturn Percentage (%)
Outpatient Services	11	12	23	48%
DME	5	3	8	38%
CalAIM related	5	1	6	17%



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**CalOptima
Health**

Grant Management Activities and Updates

October 2026

**Danielle Cameron, Senior Director,
Grant Programs, Medi-Cal/CalAIM**

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

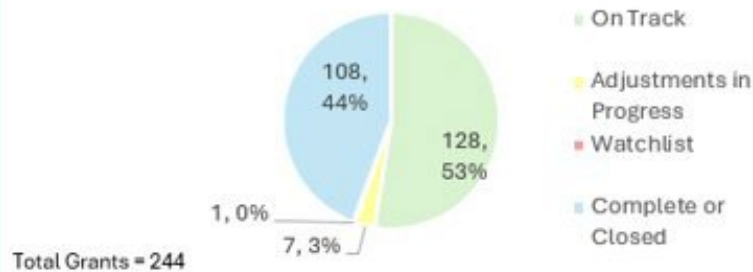
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Grants Monitoring Report

CalOptima Health Grants Monitoring Report Prepared September 22, 2026

Current Pulse Check Across All CalAIM Grants



Grant Assessment Key

- Grant program is on track for timeline, objectives and budget.** All reports and progress meet expectations.
- Grant program is delayed or off track and adjustments are in progress.** Staff is actively working with grantee to address program or spending performance. The program is not at risk, but needs additional attention to ensure it stays aligned.
- Grant program is on a watch list and not progressing enough toward outcomes or spending.** Grantees are completing Performance Improvement Plans. Staff are actively involved to ensure program can be returned to "on track." Executive team or legal counsel advise on any potential agreement amendments, recoupment of funds, or other actions needed.
- Grant program completed or terminated upon mutual agreement.**

	Portfolios Under Active Management*	Portfolio Value	# of Grants	Status Breakdown Across Each Portfolio
1	Behavioral Health Grants	\$ 9,571,250	3	3
2	Street Medicine	\$ 23,460,083	7	2 1 4
3	HHIP- Round 1	\$ 36,631,423	35	4 31
4	HHIP- Round 2	\$ 52,300,000	15	6 9
5	HHIP- Round 3	\$ 25,780,000	14	5 2 7
6	HHIP – Round 4	\$ 2,700,000	6	1 1 4
7	HHIP – Round 5*	\$ 10,000,000	6	6
8	Pulse for Good	\$ 660,000	22	15 7
9	Community Enrollers Round 1	\$ 4,073,325	12	3 9
10	Community Enrollers Round 2	\$ 2,200,000	7	7

Grants Monitoring Report (continued)

11	Community Enrollers Round 3	\$ 3,552,548	7	7	
12	ECM Academy Cohort 3	\$ 1,200,000	12	10	2
13	Justice Involved Learning Network	\$ 1,000,000	5	5	
14	Cancer Screening Program	\$ 16,417,044	15	15	
15	Quality Improvement Grants (MY2023)	\$ 4,633,957	37	2	35
16	Quality Improvement Grants (MY2024)	\$ 1,752,482	8	8	
17	Workforce Development Round 1	\$ 24,596,300	7	7	
18	Workforce Development Round 2	\$ 5,140,772	6	6	
19	UCI HPSP Evaluation	\$ 269,703	1	1	
20	OCHCA - Be Well Hubs (Orange/Irvine)	\$ 11,400,000	1	1	
21	CSUF - MSW Stipend Program	\$ 5,000,000	1	1	
22	Coalition - PHVBC	\$ 50,000,000	1	1	
23	OCHCA - CHIP/CHA	\$ 990,678	1	1	
24	Food Bank Grants	\$ 4,200,000	4	2	2
25	Equity and Practice Transformation	\$ 1,275,000	11	11	
TOTAL		\$ 300,103,725	244		

* Three of these grants are technically amendments/increases to prior awards.

**Portfolios are removed from this list after being 100% closed for at least one month.

Grant Management Updates

Grant Monitoring

- Street Medicine

- Yellow: AltaMed has been placed on a PIP until they increase their panel numbers and bill for services rendered.

- HHIP R3

- Yellow: Golden State Recuperative Care project has found new potential and is continuing to work with the City of Costa Mesa to move the project forward.
- Yellow: Casa Youth Shelter is behind schedule but continue to actively pursue approved construction permits. We provide monthly check-ins for extra support until they are on track with permits and construction begins.

- HHIP R4

- Yellow: Orangewood Foundation is on a PIP until they increase the number of TAY living in their center, an objective of their grant agreement.

Grant Management Updates

Grant Monitoring

- ECM Academy Cohort 3
 - Yellow: Two of the grantees, Nurturing Care and Mercy Pharmacy have not yet met their service objective (serve 30 individuals with ECM) and are receiving a short no-cost extension until they meet that threshold.
- OCHCA Be Well Hubs
 - Yellow: They are behind schedule in expending their funds, leadership have collectively agreed to terminate the contract and OCHCA will return the remaining funds.
- Coalition of Orange County Community Health Centers
 - Red: They have outstanding audit findings that will be in the process of being resolved.



**Board of Directors’
Quality Assurance Committee Meeting
October 15, 2026**

Quality Improvement Health Equity Committee (QIHEC) Second Quarter 2026 Report

QIHEC Summary	
QIHEC Chair(s)	Quality Medical Director and Chief Health Equity Officer
Reporting Period	Quarter 2, 2026
QIHEC Meeting Dates	April 14, 2026, May 12, 2026, June 09, 2026

April 14, 2026, QIHEC Meeting
Compliance: No compliance issues were reported. Review/Approval of March 10, 2026, Meeting Minutes: The committee reviewed and approved the meeting minutes. Chief Medical Officer (CMO) Update: The CMO gave an update on measles outbreaks, vaccination rates, and ongoing vigilance against fraud, waste, and abuse. CalOptima Health’s internal controls and collaboration with the Department of Justice (DOJ) were emphasized. 2026 QI Work Plan: Key changes included adjusting health equity targets to meet the aggregate rate, setting separate goals for provider race and ethnicity data collection and adding a Quality Assurance Performance Improvement (QAPI) program for long-term care. Grievance and Appeals (GARS) Committee: - The GARS Committee met on March 12, 2026, with a quorum, approved prior minutes, and reviewed Q4 2025 trends. The committee reported a significant drop in discrimination grievances (103 → 40) due to interventions with transportation vendors. Appeals remained steady, with high compliance and reduced overturn rates. - Nurse specialist triage improved categorization accuracy and contributed to reductions in Quality-of-Care (QOC) grievances. Quality of service remains the top grievance category for both lines of business, and access is the second. Discrimination grievances dropped significantly National Committee for Quality Assurance (NCQA) Accreditation Updates: - On track to collect Year One deliverables for Medicaid Health Plan Accreditation. Ongoing remediation and corrective action plans address audit findings, especially in credentialing across four CalOptima Health networks. - New standards released for Health Outcomes Survey with a plan to conduct staff training. - Seeking Interim Health Plan Accreditation for Covered California. CalOptima Health Comprehensive Community Screening Program (CCCSP):

April 14, 2026, QIHEC Meeting

- The CCCSP reported 35,583 screenings in Year 1, with ongoing efforts to track cancers found and reduce late-stage diagnoses.
- Performance concerns were discussed, and a formal six-month reassessment was recommended for grantees with declining rates.

Behavioral Health Quality Measures:

- Summary of Measure Changes (Year-over-Year Comparison)
 - Metabolic Monitoring for Children & Adolescents on Antipsychotics (APM): Rate decreased from 8.49% to 6.28%.
 - Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD): Rate decreased from 30.44% to 23.14%.
 - Care Coordination & Follow-Up After ED Visits (Follow-Up After ED Visit for Mental Illness (FUM), Follow-Up After ED Visit for Alcohol and Other Drug Dependence (FUA), Follow-Up After ED Visit for Other Issues (FUI) Rates increased across all 7-day and 30-day mental health and substance use follow-up measures.
 - Medication Management (Antipsychotic Medication Management (APP), Prescription Opioid Dependence (POD): APP increased by 2.29 percentage points; POD increased by 0.34 percentage points.
 - Depression Screening & Follow-Up (DSF-E): Medi-Cal screening increased from 0.00% to 0.25%; OneCare increased by 4.08 percentage points.
 - Postpartum Depression Follow-Up (PDS-E): Follow-up decreased from 100% to 64.29%; screening increased from 1.39% to 5.66%.
- Prenatal Depression Screening & Follow-Up (PND-E): Rate increased from 66.67% to 76.92%
- Several quality measures improved, particularly in care coordination and follow-up after an ED visit.
- Some measures, notably metabolic monitoring and diabetes screening, remain below benchmarks and require targeted interventions.
- Key barriers identified include challenges with member engagement, data reliability and limitations in available data.
- The Performance Improvement Plan (PIP) enrollment goal was met, but continued collaboration and process improvements are needed.

2025 Member Experience Survey (Behavioral Health)

- There were low response rates for these surveys, reflecting ongoing challenges in member engagement and outreach.
- To address these barriers, the team plans to simplify survey questions, introduce QR-coded postcards, and move to quarterly distribution with provider support.

Medication Adherence:

- Extended-day supplies of behavioral health medications, up to 100 days, are broadly available under OneCare and Medi-Cal Prescription (RX), with exceptions for safety or formulary reasons.
- Conducted outreach calls to members, providers and pharmacies for medication refills past due or at-risk for past due.

Cultural & Linguistic Accessibility:

- Language services consistently meet expedited timelines, achieving a 99% on-time rate in Q1 2026. Interpreter services—offered in person, by phone, and via video—maintained a 98% completion rate, with increased demand for Korean, Arabic, and Russian interpreters.

April 14, 2026, QIHEC Meeting

- The team enhanced feedback collection through new member and staff surveys, shifting to a mail-in survey for members who have used their services, and following up with a monthly text-message campaign to keep the survey top-of-mind and increase participation.

Member Demographic Data:

- The system assessment is complete, confirming that the system has the necessary fields to store demographic data, and the project is scheduled for completion in the third quarter of 2026
- A member survey draft has been completed, is under consultant review, and is on track to launch in the third quarter to collect member disability data.

Responsive Workforce:

- CalOptima Health is ahead of schedule on employee training, with all staff completing the Optimal Health Outcomes module in November 2025 as part of annual compliance. This training, delivered through the Cornerstone system and assigned to new hires, focuses on improving the quality of care and reducing health disparities.
- A consultant assessment is underway to confirm the module meets required standards; if not, an alternative will be selected. Incorporating the training into compliance ensures 100% participation and exceeds baseline requirements.

Health Equity:

- In 2025, CalOptima Health transitioned from direct service provision to a broader focus on integrating health equity across all operations, guided by mandates and policy requirements.
- Efforts targeted low-performing quality measures and underserved populations, with tailored interventions such as improving flu vaccination rates.
- New guiding principles for 2026, learning together, member-centered care, engagement, partnership, and data-driven decisions, will shape ongoing work to reduce disparities and embed equity into governance.
- QIHEC recommended a centralized location on the CalOptima Health website for all Health Equity materials, making them accessible to both providers and members.

Items Approved by QIHEC

- Approval of March 10, 2026, QIHEC meeting minutes.

Items Accepted & Filed

- GARS Committee November 13, 2025, meeting minutes.

May 12, 2026, QIHEC Meeting

Compliance: No compliance issues reported.

Review/Approval of April 14, 2026, Meeting Minutes: The committee reviewed and approved the meeting minutes.

Chief Medical Officer Update: No CMO update was reported.

Policy Updates: The following policies on quality measure rate production, pay-for-value programs, and post-hospital discharge medication supply were approved.

- Policy GG.1601: Quality Measure Rate Production and Data Sharing Requirements for Directed Payment Initiatives and Alternative Payment Methodology Programs (New)
- Policy GG.1640: Health Network Pay for Value Program (New)
- Policy GG.1639: Post-Hospital Discharge Medication Supply (Revised)

Quality Performance:

May 12, 2026, QIHEC Meeting

- Notable improvements were observed in cervical cancer screening, follow-up care after Emergency Department (ED) visits for mental health or substance abuse concerns, and prenatal depression screening.
- The following measures did not perform as well as in the previous year: breast cancer screening, developmental screening, and postpartum depression follow-up.

Cozeva PayerOne Software Solution:

- Cozeva is being deployed to provide real-time gap closure, automated quality data extraction, and monthly provider incentive payments, with Electronic Health Record (EHR) integration expanding across high-volume groups.
- Measure validation to be completed in May 2026.
- Provider engagement is supported through training, field-visit assistance, account linking, and compatibility with common EHRs (including Office Ally), while onboarding continues for networks not yet fully integrated (Noble, Regal).

At-Home Programs:

- In Q1, 683 home visits were completed, with 93% of tested members achieving a Hemoglobin A1c (HbA1c) below 9.
- Key lessons include confirming addresses, using wraparound communication, and providing clear instructions and “how-to” videos.
- The program is being refined based on member feedback and aims to increase engagement, improve chronic disease management, and close care gaps for high-risk populations.

At-Home Lab Testing:

- Varied in response rates, with higher engagement among Medi-Care members (14.8%) and lower participation from Medi-Cal members. The team is reviewing outreach strategies and considering focusing on the urine test option to improve ease of use and participation.
- The Cologuard at-home colorectal cancer screening program saw response rates of 18% among Medi-Care members and 11% among Medi-Cal members. Lessons learned include the effectiveness of wraparound messaging and the need for clearer instructions, prompting exploration of instructional videos and supportive materials to boost member completion rates.

Quality Performance Reporting:

- Healthcare Effectiveness Data and Information Set (HEDIS) reporting is nearly complete, with all Managed Care Accountability Set (MCAS) measures passing except for FUA and FUM, which fell short of minimum performance levels.
- The medical records review process is finished, auditors are validating results, and final submissions to NCQA, CMS, and the Department of Health Care Services (DHCS) were scheduled for June.

Value-Based Payment Program - Health Network: The report was deferred to July pending final HEDIS results, as the calculations rely on finalized data. In the interim, the team continues to monitor performance and implement targeted interventions to address underperforming measures.

Value-Based Payment Program – Behavioral Health:

- The Applied Behavior Analysis (ABA) Pay for Value (P4V) program has seen progress across key metrics, including increased rates of monthly direct services and supervision.
- The Mental Health P4V program's continued improvement is anticipated as incentive structures mature.
- Both programs are in active payout cycles.

Value-Based Payment Program - Hospital:

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- Managed Care Plans (MCPs) must now calculate quality measures using DHCS California Technical Specifications and supply key data files, including enrollment, claims, pharmacy, ADT feeds, and gaps-in-care, to support accurate performance rates.
- CalOptima Health is collaborating with the University of California, Irvine (UCI) to align data workflows and technical requirements, with ongoing bi-weekly meetings and a long-term data exchange solution under development. These efforts aim to streamline reporting, reduce discrepancies, and position MCPs as the single source of truth for member data.

Population Health Management (PHM) Strategy:

- Keeping Children Healthy with Performance Improvement Project (PIP): While minimum performance levels were met in 2025, key measures, especially among Black/African American, White, and Native Hawaiian/Other Pacific Islander members, remain below targets. The team is expanding culturally tailored outreach and early engagement initiatives, including targeted messaging and materials, to address low compliance and strengthen performance in priority populations.
- The Maternal Health Program conducted outreach to 1,377 CalOptima Health Community Network (CHCN) members in Q1, providing education, care coordination, and support during prenatal and postpartum periods.
 - Depression screening rates improved significantly, with postpartum screening rising from 6.12% to 13.15% and prenatal screening from 7.13% to 23.84%. The team identifies members through multiple touchpoints, including hospital and emergency department events, enabling timely connection to preventive care.
 - Outreach was conducted to 275 members who missed postpartum appointments, focused on rescheduling and reinforcing ongoing care.
 - Collaboration with the Orange County Health Care Agency connects Black maternal health members to culturally responsive services, reaching 73 members, with over half expressing interest in additional support.
 - Key initiatives include an updated PHM policy, risk stratification, and a maternal health dashboard, with outreach metrics tracked for continuous improvement.

Health Education & Disease Management:

- In Q4 2025, 1,198 health education referrals accounted for 20% of internal referrals, with continued activity in Q1 2026.
- Recent efforts emphasize chronic condition education, targeted coaching, and outreach tied to Medicare Star Ratings (STARS) gap-closure initiatives.
- Under the Health Equity Officer's leadership, the CME Planning Committee coordinates diverse training sessions for providers and care teams.
- The Health Education Resource Hub, a digital platform, offers branded content and tools to support chronic condition education and self-management, and is actively promoted in member newsletters.

Disease Management Program (Emerging Risk & Chronic Conditions Improvement Project (CCIP):

- Results showed a 6-point improvement in blood pressure and blood sugar control over the prior year.
- Recent pilots, such as Telemedicine to You (TeleMed2U) endocrinology, report strong satisfaction and faster access to specialty care.
- Outreach and engagement rates are high, with positive trends in STARS measures, especially for diabetes and kidney screenings.

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- Ongoing initiatives include at-home test kits, wellness visits, and multimodal campaigns to promote education and testing, with strong support for the Cozeva platform to drive further improvement. California Advancing and Innovating Medi-Cal (CalAIM) & Community Supports: The outcomes methodology for the Community Supports program analyzed 9,633 members with sustained eligibility before and after their first CalAIM service, excluding medically tailored meals, from January 2022 to October 2025. - There was a positive increase in healthcare utilization: primary care visits rose by 3%, behavioral health by nearly 21%, specialist visits by 18%, and nurse practitioner visits by 0.6%, indicating improved navigation and use of services. - Hospital admissions and skilled nursing facility days decreased by nearly 21% and 45%, respectively, while emergency department visits increased slightly and long-term care days rose, reflecting appropriate alignment with member needs. - The team is finalizing audits of contracted providers and developing new compliance tools to strengthen program oversight and support further. Street Medicine: - The team launched a new program site in Santa Ana on March 9, with AltaMed, and expansion will require at least two neighboring cities. - Across four sites, 439 members participated in Q1, with strong primary care engagement, and 53 members achieved permanent housing since April 2023. - The team is analyzing long-term housing stability, recognizing the importance of the first year after placement for sustained success. Special Needs Plan (SNP) Model of Care (MOC): The D-SNP Model of Care team is finalizing this year’s submission, with a strong care plan and Interdisciplinary Care Team (ICT) compliance rates. Member encounter and wellness visit rates are improving but increasing these remains a priority. Nearly 95% of members have a complete care plan, and 92% have active interdisciplinary care team support. Items Approved by QIHEC - Approval of April 14, 2026, QIHEC meeting minutes. - Policy GG.1601_Quaity Measure Rate Prod and Data Sharing Requirement for Direct Payment Initiatives and Alternative Payment Methodology - Policy GG.1639_Post-Hospital Discharge Medication Supply - Policy GG.1640_Health Network Pay for Value Program - Policy GG.1640_Attachment A - CalOptima Health Board Action Agenda Referral (November 13, 2025) Items Accepted & Filed 2026 QI Work Plan_Q1 Update

June 9, 2026, QIHEC Meeting
Oversight & Compliance: No compliance issues were reported. Chief Medical Officer Update: The CMO reported on California’s active state budget process and its impact on CalOptima Health. Multiple proposals and ongoing advocacy may lead to operational challenges, but a budget agreement is expected. CalOptima Health and the County of Orange operate separate budgets, and the County manages Medi-Cal eligibility. Policy Updates: The following policies were approved.

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- Policy GG.1205: HEDIS® Data Collection and Reporting
- Policy GG.1655, Reporting of Provider Preventable Conditions

Credentialing Peer Review:

- The CPRC met on 01/29/2026, 02/26/2026 and 03/26/2026 to review provider monitoring, fair hearing updates, board certification updates, fraud and abuse reporting, hospital audit results, credentialing policy revisions, and Potential Quality Issues (PQI) case reviews.
- Reviewed terminations, suspensions, and monitoring across specialties, with 319 initial credentialing and 305 recredentialing reported; all met compliance standards.
- The committee approved updates to credentialing policies and recognized the Royal College of Physicians and Surgeons of Canada as an acceptable board certification entity.
- Eight PQI cases were reviewed, with associated actions documented. PQI trends for July - December 2025, providers with 15 or more grievances at rates five times above their specialty were flagged for discussion. No Provider Preventable Conditions (PPC) were identified in the quarter. Facility Site Review (FSR) and Medical Record Review (MRR) were also presented.

Grievance and Appeals (GARS) Committee:

- The GARS Committee met on May 19, 2026, to approve its March minutes and review Q1 trends, drivers, and remediation for grievances and appeals, as well as access and referral challenges. In Q1 2026, member grievances decreased from 5,200 in Q4 to 4,925, with a notable 61% reduction in repeat complainants. The most common issues were provider staff attitude, authorizations, and customer service, while discrimination-related grievances increased slightly.
- Appeals declined by about 70 cases, but overturn rates rose for both Medi-Cal (36%) and OneCare (43%), mainly due to new information and unmet access standards.
- Most grievances and appeals centered on quality of service, access, and referral delays, with transportation issues also prominent. The GARS team continues to monitor these trends and implement targeted interventions

Member Experience (MemX) Committee:

- The MemX Committee meeting on April 14, 2026, focused on network adequacy and regulatory monitoring, confirming that OneCare met all 2026 CMS standards and completed 2024 alternative access submissions, with corrective action plans issued where needed.
- Plan-level monitoring found all requirements met except the provider-to-member ratio in urology, prompting targeted contracting and recruitment in South County.
- Listening Post feedback highlighted ongoing member challenges with provider access, Primary Care Provider (PCP) appointments, referral delays, test results, dental scheduling, follow-up communication, and care coordination.
- Timely access improved across most DHCS measures but remained below urgent appointment standards; internal monitoring after a second resurvey showed 79% compliance, with provider corrective actions and a new Timely Access Workgroup underway.
- Behavioral health surveys showed higher response rates and satisfaction, especially for ABA services, while satisfaction with telehealth declined, except among ABA members. Customer service satisfaction remained strong, with OneCare Q1 2026 overall satisfaction at 92.2%. Medi-Cal survey responses totaled about 7,500, and Salesforce
- Customer Relationship Management (CRM) implementation is expected to strengthen performance further.
- The committee discussed clarifying flex card activation processes and leveraging Listening Post and Just-in-Time insights for targeted interventions.

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Utilization Management:

- Utilization Management Committee (UMC) meeting on May 21, 2026, covered turnaround time performance, operational reviews, sub-workgroup activities, population health management, and pharmacy outcomes.
- The committee approved their February 19, 2026, meeting minutes and the 2026 Clinical Practice Guidelines (CPG).
- Membership trends showed declines in Medi-Cal and Whole Child Model enrollment, but growth in OneCare.
- Inpatient and prior authorization turnaround times consistently exceeded targets, and emergency room utilization and bed days were reviewed.
- Sub work groups addressed utilization, high-risk management, and benefits management, with 143 codes reviewed and 14 revised policies approved.
- The committee approved the 2026 Population Needs Assessment
- Received updates on Health Risk Assessment (HRA) text campaigns and expanded specialty access via TeleMed2U.
- Pharmacy and Therapeutics reviewed 14 new drugs, adding 10 to the OneCare formulary and updating prior authorization lists for 2026.

Whole Child Model Clinical Advisory Committee (WCM CAC):

- The WCM CAC met on May 26, 2026. Key topics included upcoming dental benefit changes effective July 1, 2026, limiting coverage for certain groups, and increased hospice oversight.
- The committee introduced a three-year Transition Age Primary Care Incentive Pilot to support California Children's Services (CCS) members as they transition to adult care, with a focus on continuity and reducing Emergency Department use.
- Preliminary behavioral health metrics highlighted the need to improve immunization rates and address gaps in allergy/immunology and genetics coverage.
- Member inquiries remained stable, and a new platform was implemented to improve responsiveness.
- Psychotherapy and ABA utilization increased, though wait-time challenges persist.
- In Q1 2026, 30,000 Adverse Childhood Experiences (ACE) screenings were performed, and dashboards for autism, depression, suicide risk, and substance use disorder (SUD) were reviewed.
- Pediatric clinical services had the highest utilization in Community Supports.
- Whole Child Model membership declined slightly, with Children's Hospital of Orange County (CHOC) Health Alliance holding the largest share.
- ED admissions decreased, inpatient bed days remained stable, and authorization turnaround times exceeded 99% compliance.
- Top grievance themes included timely access, quality of care, and telephone access.
- Pharmacy updates require International Classification of Diseases, 10th Revision (ICD-10) codes and Medicare enrollment to process claims.
- The WCM CAC meeting cadence was moved to the first month of the quarter to align with other related committee reports, with the next meeting scheduled for September 1, 2026.

Delegation Oversight:

In Q1 2026, Providence Health Network received its first audit, resulting in one corrective action plan with seven findings: six in Utilization Management and one in Credentialing. The team resolved the Post-Stabilization Authorization findings and continues to address remaining items.

- CHOC Health Alliance's audit identified 16 findings, primarily in Credentialing, due to delayed NCQA policy updates. All Credentialing findings are now closed, and Utilization Management items

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are being addressed. Emerging trends include delayed policy updates to accommodate regulatory changes and a continued focus on timely notifications, decision-making, and the consistent application of clinical criteria across health networks.

Quality Assurance for Long-Term Care:

- In Q1, Long Term Support Services (LTSS) recorded no critical incidents in nursing facilities. They reviewed 11 Potential Quality Issues (PQI) case reviews, three related to quality of care and eight to quality of service.
- The team visited 17 skilled nursing facilities to conduct audits, provide recommendations, deliver training, and coordinate with social services.
- Of 418 CHCN members in long-term care, three were discharged to the community, with two readmitted within 30 days.
- CalOptima Health's 2026 goals are to increase community discharges by 5% and reduce readmissions by 15%.
- LTSS medical case managers continue to support safe discharges through Interdisciplinary Team (IDT) meetings, Durable Medical Equipment (DME) and home health coordination, and CalAIM referrals.

Actions Approved by QIHEC

- QIHEC 05/12/2026 Meeting Minutes_Draft
- Policy GG.1205: HEDIS® Data Collection and Reporting
- Policy GG.1637: Assessing Member Experience

Items Accepted & Filed

- GARS Meeting Minutes_05.20.26_Final
- UMC_Meeting Minutes_02.19.26_Final
- WCM CAC Meeting Minutes_05.27.2026_Final



**Board of Directors' Quality Assurance Committee (QAC) Meeting
October 15th, 2026**

**Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
Second Quarter 2026 Meeting Summaries**

May 5th, 2026: PACE Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary of the Health Plan Monitoring Data and PACE Quality Initiatives

- Infection Control Subcommittee: PACE's Response to COVID-19:
 - PACE will continue to report on any updates in recommendations regarding COVID and any outbreaks or reporting trends for quality purposes.
 - There was 1 reported participant case of COVID-19 in Q1 2026, with no ER or Hospital visits related to this case.
 - Effective February 3, 2026, employees are no longer required to report COVID-19 positive test results or diagnoses to Human Resources.
 - COVID-19 latest vaccine (2025/2026) is being administered by clinic as of October 2025.
- Presentation of the Q1 2026 HPMS Elements:
 - Membership data. Q1 2026 ended with 559 total enrolled. The goal of 556 was met.
 - Immunizations
 - Pneumococcal Immunization rate in Q1 2026 was 85% (no exclusions).
 - Influenza Immunization rate in Q1 2026 was 83% (no exclusions).
 - Falls without Injury. Q1 2026 ended with 120 falls without injury. Most happened in bathroom or bedroom of home due to loss of balance.
 - Denial of Prospective Enrollees. 0 denials in Q1 2026.
 - Grievances. 7 grievances received in Q1 2026.
 - Emergency Room Visits. 141 ER visits, an increase of 29 from Q4 2025. 68 were discharged to their homes and 73 were admitted to hospital. Trends in admission diagnoses for Q1 2026: chest pain, falls, and shortness of breath. Other common admission diagnoses were pain, dizziness and giddiness and cardiac issues.
 - Medication Errors Without Injury. 2 medication errors reported in Q1 2026.

- (2) Medication Not Administered – Dose Omitted.
 - First Case: Medication was not drafted as ordered by provider
 - Second Case: Pharmacy Technician did not ensure pill was in medication bubble pack
- Both cases investigated and actions were taken
- Quality Incidents with Root Cause Analysis Reported in HPMS.
 - 12 Falls with Injury, 1 Pressure Ulcer, 6 Burns and 1 Elopement. Root cause analysis (RCA) completed for each case and shared with CMS/DHCS account managers.
- Presentation of the 2026 PACE Quality Initiatives
 - Advanced Health Care Directive
 - Goal: $\geq 55\%$ of participants will have completed AHCD by end of 2026
 - Q1 2026 ended at 37%. Goal not met at this time.
 - Dental Satisfaction Quality Initiative.
 - Goal: ≤ 1 dental-related grievance per quarter in 2026.
 - 0 dental grievances reported in Q1 2026. Goal was met.
 - Transportation Satisfaction Quality Initiative
 - Goal is ≤ 3 **valid** transportation related grievances per quarter in 2026.
 - QI received 2 total valid transportation grievances in Q1 2026. Goal was met.

May 5th, 2026: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- Presentation of Q1 2026 Quality Work Plan Elements
 - *Elements 3 – 4 Immunizations*
 - Pneumococcal Immunization rate in Q1 2026 was 92% (exclusions defined in quality work plan). Goal of 90% was met.
 - Influenza Immunization rate Q1 2026 rate is 84%. Goal of 90% was not met.
 - *Element 5: Colorectal Cancer Screening*. Goal is $>69.66\%$ will have colorectal cancer screening as defined in quality workplan. Q1 2026 rate was 78%. Goal met.
 - *Elements 6: Breast Cancer Screening*. Goal is $>83.60\%$ will have breast cancer screening as defined in quality workplan. Q1 2026 rate was 72.5%. Goal not met.

- *Element 7: Blood Pressure Control.* Goal is >87.21% of qualifying participants will have a blood pressure reading <140/90mm. Q1 2026 rate was 87.98%. Goal met.
- *Elements 8: Diabetic Eye Exams.* Goal is >89.04% of qualifying diabetic enrollees will receive annual eye exams. Q1 2026 rate was 91.1%. Goal met.
- *Elements 9: Diabetic Care – Blood Sugar Control.* Goal is <12.50% of qualifying diabetics will have blood sugar level (HbA1c) measurement of >9%. Q1 2026 rate was 7.6%. Goal met.
- *Element 10: Reduce Percentage of Falls reported by PACE Enrollees.* Q1 2026 ended with 217 per 1000 per quarter, which is above the goal of ≤150 Falls per 1000 per quarter in 2026. Goal not met.
- *Element 11: Medication Reconciliation Post Discharge (MRP).* Goal is ≥93% of participants will have medications reconciled within 7 calendar days after discharge from Hospital or SNF. Q1 2026 rate was 100%. Goal met.
- *Element 12: Access to Specialty Care.* Goal is 100% of appointments to be scheduled within 7 calendar days. Q1 2026 rate was 51%. Goal not met. In 2026, the PACE Scheduling Work Group was created to investigate numerous underlying issues causing noncompliance
- *Element 14: ACS Utilization.* Goal is ≥12% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by the end of 2026. At the end of Q1 2026, the rate was 8.9%. Goal not met.
- *Element 15: Acute Hospital Days.* Goal of <3,000 per 1000 per year was not met with 2,932 hospital days for participants in Q1 2026.
- *Element 16: ER Visits.* Goal of <820 ER visits per 1000 per year. Q1 2026 rate was 918. Goal not met.
- *Element 17: All Cause Readmissions.* Goal is <14% of hospital readmission will occur within 30 days of discharge of previous stay. The Goal for 2026 is <20% and the rate for Q1 2026 rate was 15.5%. Goal met.
- *Element 18: Number of Days to Enrollment.* New element for 2026. Goal is that 80% of participants will be enrolled into the PACE program <45 days from their initial inquiry. Q1 2026 rate was 86%. Goal met.
- *Element 19: 3 Month Disenrollments.* The goal is that <6% of controllable disenrollments are by new enrollees in 2026. Rate in Q1 2026 was 4.34%. Goal met.
- *Element 20: Total Attrition Rate.* The goal is <8% overall attrition rate in 2026. Q1 2026 rate is 4.34%. Goal met.

- *Element 21: Transportation trips <60 minutes.* Goal is that 100% of one way trips will be 60 minutes or less in 2026. There were 9 one-hour violations in January 2026, 4 in February 2026, and 8 in March 2026. PACE continues to monitor all violations and investigate whether they are considered controllable (based on poor planning) or uncontrollable (based on traffic incidents). There were a total of 2 *controllable* 1-hour violations in Q1 2026.
- *Element 22: Transportation On-Time Performance.* On time performance data gathered directly from Secure transportation report to reflect on time trips with a +/- 15-minute window. The goal is $\geq 92\%$ of all transportation rides will be on time. Q1 2026 rate was 81.9%.