Policy:	PA.7002
Title:	**Appeal Process**
Department:	CalOptima Health PACE
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 10/10/2024*
Effective Date:	10/01/2013
Revised Date:	10/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy provides for responses to, and resolution of, an Appeal as expeditiously as the Participant's health condition requires, while maintaining confidentiality, in accordance with regulatory and contractual requirements for Participants in the CalOptima Health Program of All-Inclusive Care for the Elderly (PACE).

II. POLICY

A. CalOptima Health PACE is committed to ensuring that a Participant, a Participant's Representative, or a treating provider has the right to Appeal a decision by CalOptima Health PACE to deny, defer, or modify a particular care-related service, or its decision not to pay for a service received by a Participant.

B. CalOptima Health PACE shall handle all Appeals in a respectful manner and shall maintain the confidentiality of a Participant's Appeal at all times throughout and after the Appeal process is completed. CalOptima Health PACE shall not disclose information pertaining to Appeals to PACE staff members or contracted providers, except where appropriate to resolve the Appeal.

C. Contracted providers are accountable for all Appeal procedures established by CalOptima Health PACE. CalOptima Health PACE shall monitor contracted providers for compliance with this requirement on an annual basis or on an as-needed basis.

D. General Information:

1. The PACE Program Director has primary responsibility for maintenance of the procedures, review of operations, and utilization of any patterns of Appeals to formulate policy changes and procedural improvements in the administration of the plan. The PACE Quality Improvement Department has primary responsibility to gather relevant information and to work with the appellant (Participant and/or Representative) and PACE staff members to ensure the Appeal process functions effectively.

2. CalOptima Health PACE shall continue to furnish the Participant with all services at the frequency provided in the current Plan of Care during the Appeal process.

3. CalOptima Health PACE shall not discriminate against a Participant solely on the grounds that an Appeal has been filed.

4. In order to ensure Participants have access to and can fully participate in the Appeal process, CalOptima Health PACE shall ensure the following:

    a. If the person filing the Appeal does not speak English, a bilingual PACE staff member is available to facilitate the process. If a PACE staff member is not available, translation services/interpreter shall be available.

    b. All written materials describing the Appeal process shall be provided to Participants in accordance with CalOptima Health Policy PA.1007: Delivery of PACE Services.

    c. In accordance with due process requirements outlined in the Department of Health Care Services Policy Letter (PL) 22-003: Alternative Format Selection for Members with Visual Impairments, CalOptima Health PACE must assess the benefit deadline for Participants who need the delivery of written materials in alternative formats, to take action from the adequate notice date, including all deadlines for Appeals and aid paid pending.

        i. If CalOptima Health PACE fails to offer adequate notice to a Participant with a visual impairment or other disability who needs the delivery of written materials in an alternative format, within the related federal or state timeframes, the CalOptima Health PACE Participant is deemed to have exhausted the CalOptima Health PACE internal Appeal process and may request a State Hearing, in accordance with Section III.H.1. of this Policy.

    d. CalOptima Health PACE shall maintain a toll-free number (1-844-999-7223) for the filing of an Appeal and for hearing impaired Participants TDD/TTY: 1-714-468-1063.

5. CalOptima Health PACE shall provide written information about the Appeal process to a Participant and/or their Representative upon enrollment, at least annually thereafter, and whenever the Interdisciplinary Team (IDT) denies, defers, or modifies a request for services or refuses to pay for a service. Information includes, but is not limited to:

    a. Procedures for filing an Appeal or expedited Appeal, including Participant's external Appeal rights under Medicare and/or Medi-Cal.

    b. Telephone numbers for the filing of an Appeal received in-person or by telephone:

        PACE Center: 1-714-468-1100

    c. Location where a Participant and/or their Representative may file a written Appeal:

        CalOptima Health PACE Center
        13300 Garden Grove Blvd
        Garden Grove CA 92843

6. Any method of transmission of Appeal information from one CalOptima Health PACE staff member to another shall be done with the strictest confidence, in adherence with Health Insurance Portability and Accountability Act (HIPAA) regulations.

7. CalOptima Health PACE staff shall assist the Participant in choosing which external Appeal process to pursue if both are applicable and forward the Appeal to the appropriate external entity.

E. CalOptima Health PACE shall process all Service Determination Requests (SDRs) in accordance with CalOptima Health Policy PA.2022: Service Determination Request (SDR).

III. PROCEDURE

A. Receiving Requests to Provide a Service or Pay for a Service

1. A Participant or their Representative may request to initiate, eliminate, or continue a particular service or request that CalOptima Health PACE pay for a service. A Participant or their Representative may submit the request to CalOptima Health PACE verbally by telephone, in-person, or in writing.

2. In the event a Participant or their Representative requests provision of, or payment for, a particular service, the IDT shall determine whether the requested service is necessary based on the assessed needs of the Participant. The IDT's decision is documented in the Service Request Log and in the Participant's medical record.

3. Following the receipt of a Service Determination Request, an in-person assessment may be conducted by the appropriate IDT discipline, if determined necessary. This in-person assessment needs to occur within seventy-two (72) hours of IDT's review of the Service Determination Request.

4. CalOptima Health PACE shall notify the Participant or their Representative of its decision to approve, deny, defer, or modify the request as expeditiously as the Participant's condition requires, but no later than seventy-two (72) hours after the IDT reviews the request.

    a. If the decision is to approve the requested service, without deferring or modifying provision of the service, or payment for a service, CalOptima Health PACE shall notify the Participant or their Representative verbally and/or in writing. The service shall be furnished to the Participant as determined by the IDT's revised Plan of Care.

    b. If the decision is to deny or modify a request for service, or deny payment of a service, CalOptima Health PACE shall notify the Participant or their Representative verbally and in writing. If the Participant or their Representative appeals the denial, CalOptima Health PACE shall initiate the Appeal Process in accordance with this policy.

    c. If the decision is to defer a request for service, the IDT may extend the seventy-two (72) hour timeframe by no more than five (5) additional calendar days for either of the following reasons:

        i. The Participant or their Representative requests the extension.

        ii. The team documents its need for additional information from an outside specialist and how the delay is in the best interest of the Participant.

    d. If the IDT requests an extension to make a decision, they must notify the Participant or their Representative verbally and/or in writing within twenty-four (24) hours.

B. Notification of a Decision to Deny, Defer, or Modify a Request for Service or Deny Payment of a Service

1. At the time of the decision, CalOptima Health PACE shall inform the Participant, and as appropriate, the treating Provider, of the reason for denial, deferral, or modification of a service or denial of payment for a service.

2. Notification of the denial, deferral or modification of service or denial of payment is made both verbally; either in-person or by telephone, and in writing, utilizing the Notice of Action (NOA) for Service or Payment Request Form by the assigned IDT member or designee. .

3. The assigned IDT member or designee shall document in the medical record that a denial, deferral, or modification of service or denial of payment was made.

4. The assigned IDT member or designee shall document in the medical record that Appeal rights were given to the Participant.

5. The assigned IDT member or member of the CalOptima Health PACE Quality Improvement Department shall notify the Participant in writing of their right to Appeal the denial for reconsideration by CalOptima Health PACE and of their external Appeal rights, using the Information for Participants about the Appeal Process Notice.

6. If the IDT fails to provide the Participant with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and CalOptima Health PACE must automatically process the Participant's request as an Appeal.

C. Filing an Appeal

1. The Appeal process is available to any Participant, their Representative, or the treating Provider who disputes denial of payment for a service or the denial, deferral, or modification of a service by the Primary Care Provider (PCP) or any member of the IDT who is qualified to make referrals.

2. An Appeal for denial, deferral, or modification of a service or payment for a service may be filed verbally or in writing.

    a. A Participant and/or their Representative may verbally request an Appeal by speaking to any PACE staff member. The PACE staff member who receives information from a Participant and/or their Representative regarding filing an Appeal will advise the social worker or designee, who will follow up with the Participant.

    b. At the time of denial, or at any time upon request, the social worker shall provide the Participant and/or their Representative with an Appeal for Reconsideration of Denial Form. The Participant and/or their Representative shall complete the form and submit the form to any CalOptima Health PACE staff member, who shall route the form to the PACE Quality Improvement Department. This shall constitute a written request to Appeal the CalOptima Health PACE decision.

    c. The PACE social worker, Quality Improvement Department, or other designee shall assist the Participant and/or their Representative in filing an Appeal in the event assistance is required.

3. Upon receipt of the Appeal for Reconsideration of Denial Form, the PACE Quality Improvement Department shall notify either the Program Director or the Medical Director of the Appeal:

    a. PACE Medical Director: Appeals related to disputed clinical health care services.

b. PACE Program Director: Appeals related to disputed health non-clinical care services or payment issues.

4. An Appeal may be filed as a standard Appeal or an expedited Appeal, depending on the urgency of the case:

   a. A standard Appeal may be filed verbally or in writing with any PACE staff member within one hundred eighty (180) calendar days of a denial of service or payment. The one hundred eighty (180) calendar day limit may be extended for good cause by CalOptima Health PACE on a case-by-case basis.

   b. An expedited Appeal may be filed verbally or in writing, to CalOptima Health PACE if the Participant or treating Provider believes that the Participant's life, health, or ability to regain or maintain maximum function would be seriously jeopardized without provision of the service in dispute.

   c. In the case of an expedited Appeal, the PACE Quality Improvement Department shall immediately contact the PACE Medical Director by telephone.

5. For Participants enrolled in Medi-Cal, CalOptima Health PACE shall continue to furnish the disputed service if CalOptima Health PACE is proposing to terminate or reduce services currently being furnished to the Participant and the Participant requests continuation with the understanding that they may be liable for the costs of the contested services if the determination is not made in their favor. In these cases, CalOptima Health PACE shall not discontinue the disputed service for which an Appeal was filed until the Appeal process concludes.

D. Acknowledgement of Receipt of Appeal

1. The PACE Quality Improvement Department shall acknowledge a standard Appeal in writing within five (5) business days of the initial receipt of the Appeal by CalOptima Health PACE.

2. For an expedited Appeal, the PACE Quality Improvement Department shall inform the Participant or Representative within one (1) business day, by telephone or in-person, that the request for an expedited Appeal was received and explain additional Appeal rights, as applicable.

E. Documentation of Receipt of Appeal

1. CalOptima Health PACE shall document all Appeals expressed either verbally or in writing on the day that the Appeal is received, or as soon as possible after the event or events that precipitated the Appeal, in an Appeal Log.

2. Appeals are documented on the Appeal for Reconsideration of Denial Form by the Participant, their Representative, or by a treating provider on behalf of the Participant. Complete information is required so that the Appeal can be resolved in a timely manner.

3. In the event of insufficient information, the PACE Quality Improvement Department shall take all reasonable steps to contact the Participant, and/or their Representative or other appropriate parties to the Appeal to obtain missing information in order to resolve the Appeal within the designated timeframes for an expedited or standard Appeal.

F. Reconsideration of Decision for Service Request or Payment of a Service

1. A Third Party Reviewer shall review and decide an Appeal. The third party shall be someone who is appropriately credentialed and an impartial third party who was not involved in the original action, and who does not have a stake in the outcome of the Appeal. The third-party reviewer may either uphold or reverse the decision rendered by CalOptima Health PACE IDT.

2. The PACE Quality Improvement Department shall gather all applicable documentation and information related to the Participant's denial, including medical records, lab results, provider notes, claims, and interviews and forward documentation and information to the third party for a review and determination of the Appeal. The PACE Director, the PACE Medical Director, or the PACE Quality Improvement Manager will appropriately document on the Appeal Case Review Form.

3. All individuals involved with the Appeal, including the Participant or their Representatives, shall be given written notice of the Appeals process and reasonable opportunity to present evidence or submit relevant facts for review to CalOptima Health PACE, either verbally or in writing.

4. For a standard Appeal, the PACE Quality Improvement Department shall inform the Participant in writing of the decision to reverse or uphold the decision within thirty (30) calendar days of receipt of an Appeal, or more quickly if the Participant's health condition requires.

5. For an expedited Appeal, CalOptima Health PACE shall make a decision regarding the Appeal as promptly as the Participant's health condition requires, but no later than seventy-two (72) hours after receipt of the request for Appeal.

    a. If a Participant's request for expedited Appeal is not supported by a physician, CalOptima Health PACE Medical Director shall decide if the Participant's health situation requires making a decision within seventy-two (72) hours. If the Participant's health does not warrant an expedited Appeal process CalOptima Health PACE Medical Director shall notify the Participant within seventy-two (72) hours that the Appeal will be treated as a standard Appeal.

    b. The PACE Quality Improvement Department shall provide the Participant, or their Representative, and the Department of Health Care Services (DHCS) with a written statement of the final disposition or pending status of an expedited Appeal within seventy-two (72) hours of receipt of an Appeal.

    c. In the event the seventy-two (72) hour timeframe must be extended CalOptima Health PACE will provide justification to DHCS for the need for the extension. The PACE Quality Improvement Department shall notify the Participant, both verbally and in writing, of the pending status and reason for the delay in resolving the appeal. CalOptima Health PACE shall notify the Participant of the anticipated date by which the Appeal decision shall be determined.

G. Determination of an Appeal

1. When the decision of an Appeal is in favor of a Participant that is, the decision to deny, defer, or modify a service or payment of a service is reversed, the following shall apply:

    a. The PACE Quality Improvement Department shall mail a written response to the Participant and/or Representative within thirty (30) calendar days of receiving a standard Appeal, or sooner if the Participant's health condition requires.

b. CalOptima Health PACE shall provide authorization to furnish the disputed service as quickly as the Participant's health condition requires, but no later than thirty (30) calendar days from the receipt of the request for a standard Appeal.

c. For an expedited Appeal, CalOptima Health PACE shall provide the Participant permission to obtain the disputed service as quickly as the Participant's health condition requires, but no later than seventy-two (72) hours from the receipt of a request for an expedited Appeal.

d. If the decision to deny payment for a service is reversed by CalOptima Health PACE, then payment shall be made within sixty (60) calendar days of receiving the Participant's or Representative's request for a standard or expedited Appeal.

2. When the decision of an Appeal is not in favor of the Participant that is, the decision to deny, defer, or modify provision or payment of a service is upheld, or if the Participant is not notified of the decision within the specified time frame for a standard or expedited Appeal, the PACE Quality Improvement Department shall do the following:

   a. Notify the following in writing, at the time the decision is made, and within thirty (30) calendar days from the date of the request for a standard Appeal and within seventy-two (72) hours for an expedited Appeal:

      i. The Participant and/or their Representative;

      ii. Health Plan Management System (HPMS); and

      iii. Integrated Systems of Care Division, Department of Health Care Services.

   b. Notify the Participant and/or their Representative in writing of their Appeal rights through the Medicare or Medi-Cal program, or both, depending on the Participant's eligibility.

   c. Offer to assist the Participant or Participant's Representative in choosing which external Appeal route to pursue, if desired, and to assist in preparation of Appeal.

   d. Forward the Appeal to appropriate external entity.

H. External Review Options for Appeal

1. Medi-Cal External Appeal Process: This option for external Appeal is available to Participants enrolled in Medi-Cal, that is, Medi-Cal only or both Medi-Cal and Medicare:

   a. If the Participant and/or Representative chooses to Appeal using the Medi-Cal external Appeal process, the PACE Quality Improvement Department shall assist the Participant and forward the Appeal to:

      California Department of Social Services
      State Hearings Division
      PO Box 944243 Mail Station 19-37
      Sacramento CA 94244-2430

      Telephone: 1-800-952-5253
      Facsimile: (916) 229-4410
      TDD: 1-800-952-8349

2. CalOptima Health PACE shall not discontinue services for which an external Appeal is filed until the External Appeal process concludes. However, if CalOptima Health PACE's initial decision to deny, discontinue, or reduce a service is upheld, the Participant may be financially responsible for the cost of the disputed service provided during the external Appeal process.

3. If a Participant and/or their Representative decide to pursue a State Hearing, they must request the State Hearing within ninety (90) calendar days from the date of the notice of action (NOA). A Participant and/or their Representative may speak at the State Hearing, or have someone else speak on the Participant's behalf, including a relative, friend, or an attorney.

    a. For legal assistance, the Participant and/or their Representative may be able to receive free legal assistance. To facilitate this, the PACE Quality Improvement Department shall provide a listing of Legal Services Offices to the Participant and/or their Representative.

    b. CalOptima Health PACE is required to provide written position statements whenever notified by DHCS that a Participant has requested a State Hearing. CalOptima Health PACE shall designate appropriate PACE staff members to provide testimony at State Hearings whenever notified by DHCS of the scheduled time and place for a State Hearing.

    c. If the Administrative Law Judge's (ALJ) decision is in favor of the Participant's Appeal, CalOptima Health PACE shall follow the ALJ's instruction as to the timeline for provision of services to the Participant or payment for services for a standard or expedited Appeal.

    d. If the ALJ's decision, adopted by the Department of Health Care Services (DHCS) Director as final, is not in favor of the Participant's Appeal, the Participant may request a re-hearing with the DHCS Director within thirty (30) calendar days after receiving the final decision.

    e. Within one (1) year after receiving notice of the DHCS Director's final decision, the Participant may file a petition with the superior court, under the provisions of Section 1094.5 of the Code of Civil Procedure.

4. Participants who are eligible for both Medicare and Medicaid have the right to external review by means of either the Independent Review Entity or the State Hearing process per 42 CFR 460.124(c).

5. Medicare External Appeals Process: This option for external Appeal is available to Participants enrolled in Medicare, that is, Medicare only or both Medicare and Medi-Cal:

    a. A Medicare enrollee may choose to Appeal CalOptima Health PACE's decision using Medicare's external Appeals process. CalOptima Health PACE shall send the Appeal to the current contracted Medicare Appeals entity:

        Maximus Federal Services
        Medicare Managed Care & PACE
        Reconsideration Project
        3750 Monroe Avenue Suite 702
        Pittsford NY 14534-1302

        Telephone: 1-585-348-3300

    b. The current contracted Medicare Appeals entity maintains a standard and expedited Appeal process.

i. Standard Appeals are resolved within thirty (30) calendar days after filing of the Appeal;

ii. Expedited Appeals are resolved with seventy-two (72) hours, with a possible fourteen (14) calendar days extension.

c. The current contracted Medicare Appeals entity shall contact CalOptima Health PACE with the results of the review. That entity shall either uphold CalOptima Health PACE's original decision or reverse CalOptima Health PACE's decision and rule in the Participant's favor.

d. If the decision of current contracted Medicare Appeals entity is not in the Participant's favor, there are further levels of external Appeal, and if requested by the Participant and/or their Representative, the PACE Quality Improvement Department shall assist a Participant in further pursuing the Appeal.

I. Documentation, Tracking, Analysis and Reporting

1. CalOptima Health PACE shall keep all Appeals and related information confidential.

2. All Appeal-related information and correspondence, including the Appeal Log, shall be stored in restricted access electronic folders.

3. The Appeal Log shall contain, at a minimum, the following information:

a. Name of the staff person recording the Appeal;

b. Filing date of the Appeal;

c. Name of the Participant, Representative, and/or person filing the Appeal;

d. Description of the Appeal;

e. Action taken;

f. Description and date of the final resolution;

g. Notice of Action for Service or Payment Request form date provided to Participant; and

h. Appeal for Reconsideration of Denial Form date provided to Participant.

4. The PACE Quality Improvement Department is responsible for maintaining, aggregating, and analyzing information related to Appeals to identify trends or patterns. The PACE Quality Improvement Department shall report Appeal trends to the Board of Director's Quality Assurance Committee on a regular basis, at a minimum quarterly. The Board of Director's Quality Assurance Committee shall include this information in its report to the CalOptima Health Board of Directors.

5. CalOptima Health PACE shall submit a summary of all Appeals in the quarterly report to the Long Term Care Division of DHCS and CMS. The DHCS Appeals summary is due forty-five (45) calendar days from the date of the end of the reporting quarter.

6. CalOptima Health PACE shall hold records of all Appeals confidential and make the records available as needed to State and Federal agencies upon request.

7. CalOptima Health PACE shall maintain in its files, copies of all Appeals, the responses, and recording of log for ten (10) years from the date the Appeal was filed.

8. To ensure timeliness and accuracy in the Appeal process, CalOptima Health PACE shall perform regular audits of the Appeal log and files to ensure they correspond with other data reporting systems such as HPMS reports.

J. Annual Review

1. The PACE Program Director shall ensure that the Appeals process is reviewed with Participants and/or their Representative, contracted providers, and all employees of CalOptima Health PACE on an annual basis.

a. PACE employees shall review the Appeals process and provide written information on the Appeals process to Participants whenever CalOptima Health PACE denies a request for services or payment. All PACE Participants are provided information on the Appeals process in the PACE Annual Notices Newsletter.

b. The PACE Program Director, or designee, shall review the Appeals process with contracted providers who are providing direct care to Participants at the PACE Center annually, either in writing or through a presentation.

c. The PACE Program Director, or designee, along with the Quality Improvement Department, shall review the Appeals process annually with all PACE staff.

K. Facility Site Review

1. The CalOptima Health PACE Center shall adhere to a ten (10)-business day timeframe to initiate a Facility Review (FSR) in response to a Participant complaint that communication has been unsuccessful in accordance with CalOptima Health Policy GG.1608: Full Scope Site Reviews.

IV. ATTACHMENT(S)

A. Notice of Action for Service or Payment Request
B. Information for Participants about the Appeals Process Notice
C. Appeal for Reconsideration of Denial Form
D. Letter of Acknowledgement of Receipt of Appeal
E. Notice of Appeal Resolution
F. Notice of Appeal Decision
G. Legal Services Listing
H. Appeal Log
I. Appeal Case Review Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for PACE
B. CalOptima Health PACE Program Agreement
C. CalOptima Health Policy GG.1608: Full Scope Site Reviews
D. CalOptima Health Policy PA.1007: Delivery of PACE Services
E. CalOptima Health Policy PA.2022: Service Determination Request (SDR)
F. Code of Civil Procedure, §1094.5

G. Department of Health Care Service (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
H. Department of Health Care Service (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates
I. Department of Health Care Service (DHCS) Policy Letter (PL) 22-003: Alternative Format Selection for Members with Visual Impairments
J. Department of Health and Human Service Guidance Memorandum: Title VI Prohibition Against National Origin Discrimination—Persons with Limited-English Proficiency, 65 FR 52762
K. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), Federal Register Volume 64, No. 226
L. Title 42, California of Federal Regulations (CFR), §§ 460.104, 460.122 and 460.124

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2013	PA.7002	Appeal Process	PACE
Revised	12/01/2014	PA.7002	Appeal Process	PACE
Reviewed	01/01/2015	PA.7002	Appeal Process	PACE
Revised	02/01/2016	PA.7002	Appeal Process	PACE
Revised	07/01/2016	PA.7002	Appeal Process	PACE
Revised	10/01/2017	PA.7002	Appeal Process	PACE
Revised	03/01/2018	PA.7002	Appeal Process	PACE
Revised	04/01/2019	PA.7002	Appeal Process	PACE
Revised	07/01/2022	PA.7002	Appeal Process	PACE
Revised	09/01/2023	PA.7002	Appeal Process	PACE
Revised	10/01/2024	PA.7002	Appeal Process	PACE

IX. GLOSSARY

Term	Definition
Appeal	A Participant's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Disputed Health Care Service	Any health care service eligible for payment under the enrolled Participant's contract with CalOptima Health PACE that is denied, modified or delayed by a decision of CalOptima Health PACE, in whole or in part due to the finding that the service is not necessary.
Interdisciplinary Team (IDT)	A team composed of members qualified to fill, at minimum, the following roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of Participants: 1. Primary Care Provider: Primary medical care must be furnished to a Participant by any of the following: a. A primary care physician. b. A community-based physician. c. A physician assistant who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. d. A nurse practitioner who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. 2. Registered Nurse; 3. Master's –level Social Worker; 4. Physical Therapist; 5. Occupational Therapist; 6. Recreational Therapist or Activity Coordinator; 7. Dietician; 8. PACE Center Manager; 9. Home Care Coordinator; 10. Personal Care Attendant or his or her representative; and 11. Driver or his or her representative
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
PACE Center	The location designated by CalOptima PACE at which Members shall receive PCP services.
Participant	An individual enrolled in the CalOptima Health PACE program.
Primary Care Provider (PCP)	A provider responsible for supervising, coordinating, and providing initial and Primary Care to Participants; 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.
Representative	A person who is acting on behalf of or assisting a Participant, and may include, but is not limited to, a family member, a friend, a CalOptima Health PACE staff member, or a person legally identified in a Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Term	Definition
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.