Policy:	PA.1000
Title:	**CalOptima Health PACE Glossary of Terms**
Department:	CalOptima Health PACE
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 09/24/2024*
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Applicable to:	☐ Medi-Cal ☐ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines terms used in CalOptima Health's PACE policies and procedures, unless otherwise expressly stated.

II. DEFINITIONS

Action: A termination, suspension, or reduction (which includes denial of a service based on OGC interpretation of 42 CFR 431) of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

Actual Non-Service Expenditures: Actual amounts CalOptima Health PACE incurred for non-service expenditures, including both administrative and care management costs, for Full Benefit Dual Eligible Members and excludes costs incurred by CalOptima Health PACE prior to the start of this Risk Corridor. Any reinsurance costs reflected will be net reinsurance costs.

Actual Service Expenditures: Actual amount paid by CalOptima Health PACE for providing services to Full Benefit Dual Eligible Members priced at CalOptima Health PACE fee level and shall comprise of all provider payments for services to this population, including risk-sharing arrangements or sub-capitation payments.

Adjusted Non-Service Expenditures: CalOptima Health PACE Actual Non-Service Expenditures, adjusted to reflect the exclusion of costs greater than 125 percent of the non-medical cost per Member per month across all participating CalPACE organizations and including any consideration given to CalOptima Health PACE for any significant, non-typical membership mixes that may cause this exclusion to come into effect as well as the exclusion of reinsurance costs which is the net of reinsurance premiums; and adjustments resulting from DHCS' review of CalOptima Health PACE non-service expenditures to address any inappropriate or excessive non-service expenditures, including executive compensation and stop loss expenditures.

Adjusted Service Expenditures: CalOptima Health PACE Actual Service Expenditures adjusted to reflect the following reductions from any recoveries of other payers outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Member contributions to care; and adjustments resulting from DHCS' review of CalOptima Health PACE reimbursement methodologies and levels to address any excessive pricing.

Administrative Costs: Only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

Adult Day Health Care (ADHC): An organized day program of therapeutic, social and health activities and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in California Code of Regulations, title 22, Section 78007.

Adult Day Health Care (ADHC) Center: A facility licensed to provide adult day health care, or a distinct portion of a licensed health facility in which such care is provided in a specialized unit, under a special permit issued by the Department of Public Health pursuant to California Code of Regulations, title 22, section 54105.

Advance Directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under California law, relating to the provision of health care when the Participant is incapacitated.

Affiliate: An organization or person that directly or indirectly through one or more intermediaries' controls or is controlled by CalOptima Health PACE and that provides services to or receives services from, CalOptima Health PACE.

Allied Health Personnel: Specially trained, licensed or credentialed health workers other than Physicians, podiatrists, and Nurses.

Alternative Care Settings (ACS): Contracted Community-Based Adult Services (CBAS) Providers deemed qualified to provide ACS and associated services to CalOptima Health PACE Participants.

Ambulatory Care: The type of health services that are provided on an outpatient basis.

Appeal: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.

Applicant: Any Participant who has applied for Membership in CalOptima Health PACE.

Beneficiary Identification Card (BIC): A permanent plastic card issued by the State to Medi-Cal recipients of entitlement programs which is used by CalOptima Health PACE to verify Medi-Cal eligibility.

Capitated Revenues: The amount of the PACE Capitation payments/revenues paid to CalOptima Health PACE by DHCS for all services provided to participants under the DHCS PACE Contract.

Capitated Service: Any Medi-Cal Covered Service for which CalOptima Health PACE receives Capitation payment.

Caregiver: Caregivers are broadly defined as family members, friends, or neighbors who provide unpaid assistance to a person with a chronic illness or disabling condition.

Case Management: Responsibility for referral, consultation, ordering therapy, admission to hospitals, follow-up care, and prepayment approval of referred services. It includes responsibility for location, coordination, and monitoring all medical care on behalf of a Participant.

Center: A Facility operated by a PACE Organization where Primary Care is furnished to plan Members.

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.

Chemical Restraint: Medication used to control behavior or to restrict the Participant's freedom of movement that is not standard treatment for the Participant's medical or psychiatric condition. Guidelines as to the selection and dosage of drugs that may be used as Chemical Restraints shall be based on Best Practices for older individuals. Examples of Chemical Restraints that may be used are haloperidol, clonazepam, alprazolam, and olanzapine.

Claims and Eligibility Real-Time System (CERTS): The mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Cold-Call Marketing: Any unsolicited personal contact by CalOptima Health PACE with a potential Participant for the purpose of marketing (as identified within the definition of Marketing).

Community-Based Adult Services (CBAS): An outpatient, facility based service program that delivers Skilled Nursing Care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the Medi-Cal Waiver, to participants who meet applicable eligibility criteria.

Community Based Adult Services (CBAS) Provider: An ADHC center that provides CBAS services to eligible PACE Participants and has been certified as a CBAS Provider by the California Department of Aging.

Community-Based Physician (CBP): A physician who provides direct primary medical care, in the context of the interdisciplinary team, to Participants of the PACE program. Community-Based Physicians provide services in their respective offices and participate in PACE quality assessment and performance improvement projects.

Competency Assessment and Profiles: A competency tool used to assess an employee's or contractor's skills, knowledge, and abilities that must be demonstrated by direct participant care staff.

Complete Claim: A claim that can be processed without obtaining additional information from the provider of the service or from a third party.

Confidential Information: Specific facts or documents identified as "confidential" by any law, regulations or contractual language.

Contract (DHCS): The written agreement between DHCS and CalOptima Health PACE.

Contract (Provider): A written agreement between CalOptima Health PACE and service providers.

Contracting Providers: A Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home or any other individual or institution that contracts with CalOptima Health PACE to provide medical services to CalOptima Health PACE's plan Members.

Contractor: An entity doing business as CalOptima Health PACE or with CalOptima Health.

Controlled Substance: A drug or other substance, or immediate precursor included in Schedule I, II, III, IV, or V of the Federal Controlled Substances Act.

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 for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities 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.

Cost Avoid: CalOptima Health PACE bills or requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to CalOptima Health PACE paying the provider for the services rendered.

County Department: The County Department of Social Services (DSS) or other county agency responsible for determining the applicant or member's initial and continued eligibility for the Medi-Cal program.

Covered Services: Those items and services provided by CalOptima Health under the provisions of Welfare and Institutions Code, section 14132 and the California State Plan, except those services specifically excluded under Exhibit E, Attachment 1 of the CalOptima Health PACE contract, state law, or the California State Plan.

Credentialing: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.

Department of Health and Human Services (DHHS): The federal agency responsible for management of the Medicaid program.

Department of Health Care Services (DHCS): The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.

Department of Managed Health Care (DMHC): The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Diagnosis of AIDS: A clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), DHHS, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

Dietitian/Nutritionist: A person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Bus. & Prof. Code, chapter 5.65, sections 2585 and 2586).

Discharge Planning: Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Disenrollment: The Department-approved discontinuance of a Member's entitlement to receive Covered Services under the terms of the DHCS PACE Contract and the deletion from the approved list of Members furnished by the Department to CalOptima Health PACE.

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.

Dual-Eligible Beneficiary: An individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan.

Durable Medical Equipment (DME): Durable medical equipment means 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 Participant home.

Eligible Beneficiary: Any Medi-Cal beneficiary who is residing in CalOptima Health PACE's Service Area, 55 years of age or older, determined by DHCS as requiring nursing home level of care, and is able to live in a community setting without jeopardizing their health or safety, with one of the following aid codes:

1. Family aid codes 01, 02, 0A, 3E, 3L, 3M, 38, 3U, 3W, M3 SPD aid codes 20, 23, 24, 26, 27, 36, 60, 63, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 10, 13, 14, 16, 17, 1E, 1H
2. Adult aid codes 53, 81
3. Adult Expansion aid codes M1,L1.
4. SPD codes 20, 23, 24, 26, 27, 36, 60, 63, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 10, 13, 14, 16, 17, 1E, 1H, L6

Emergency Care: Covered services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima Health PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.

Emergency Management Plan: A strategy developed with steps for response and recovery from an unplanned event that could cause death or significant injury to employees, eligible beneficiaries or the public; or that can shut down business, disrupt operations, stop claims payment, cause physical or environmental damage or threaten the facility's financial standing or public image. Numerous events can be "emergencies" including: fire, hazardous material incident, flood or flash flood, hurricane, tornado, winter storm, earthquake, communications failure, radiological accident, civil disturbance, loss of a key supplier or customer, or an explosion.

Emergency Medical Condition: A condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with average knowledge of health/medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy of the health of the Participant; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Employee Interventions: Behaviors in which PACE employees provide restorative nursing, meaningful activities such as assisting with non-laborious tasks and skilled therapy services, to reduce the need for restraints or discontinue their use altogether for certain Participants. Every employee has the ability and the responsibility to respect Participants' dignity while creating the safest possible functional environment.

Enabling Device: A device that supports any of four (4) major functional categories: bed mobility, transfers, ambulation, and wheelchair locomotion.

Enrollment: The process by which an Eligible Beneficiary becomes a Member of CalOptima Health PACE.

Enrollment Agreement: A Contract between CalOptima Health PACE and Member which establishes the terms and conditions for Enrollment.

Facility: Any premise that is:

1. Owned, leased, used, or operated directly or indirectly by or for CalOptima Health PACE for purposes related in the DHCS PACE Contract; or
2. Maintained by a provider to provide services on behalf of CalOptima Health PACE.

Environmental Adaptations: Manipulations of the environment that reduce Participant agitation, wandering, fall risk, or other behaviors that might have historically resulted in the use of Physical Restraints. Examples include, but are not limited to, sound reduction, use of "soft" lighting, painting of hall handrails and doorways with sharp,

contrasting colors, "fooling/blinding" cognitively-impaired Participants to reduce wandering, and furniture height adjustment.

Federally Qualified Health Center (FQHC): An entity defined in Section 1905 of the Social Security Act (42 U.S.C. § 1396d(l)(2)(B)).

Fee-For-Service Medi-Cal: The component of the Medi-Cal Program which Medi- Cal providers are paid directly by the State.

Fiscal Year (FY): Any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, and the federal Fiscal Year is October 1 through September 30.

Grievance: 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 Insurance Portability and Accountability Act (HIPAA): The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy, and security of health information, and as subsequently amended.

Health Plan Employer Data and Information Set (HEDIS): The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

HEDIS® Compliance Audit: An audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

Indian Health Programs: Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area (California Code of Regulations, title 22, section 55000).

In-Home Supportive Services (IHSS): Services provided for Members in accordance with the requirements set forth in Welfare and Institutions Code section 14186.1(c)(1).

Initial Comprehensive Assessment (ICA): As defined in Title 42, Section 460.104 of the Code of Federal Regulations, a comprehensive multi-discipline assessment conducted on each Participant's health and social status to which is consolidated into a single plan of care.

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 members:

1. Primary Care Provider; Primary medical care must be furnished to a member by any of the following
   - A primary care physician.
   - A community-based physician.
   - A physician assistant who is licensed in the State and practices within their scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority.
   - A nurse practitioner who is licensed in the State and practices within their 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 their representative; and
11. Driver or their representative

Intermediate Care Facility (ICF): A Facility that is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in California Code of Regulations, title 22, section 51118 and has been certified by DHCS for participation in the Medi-Cal program.

Licensed Vocational Nurse (LVN): A person who specifically is prepared in the scientific basis of nursing; who is a graduate of a school of vocational nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as a L.V.N. under the supervision of a physician.

Marketing: Any activity conducted by or on behalf of CalOptima Health PACE where information regarding the services offered by CalOptima Health PACE is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima Health PACE.

Marketing Materials: Materials produced in any medium, by or on behalf of the CalOptima Health PACE that can reasonably be interpreted as intended to market to potential enrollees.

Marketing Representative: A person who is engaged in Marketing activities on behalf of CalOptima Health PACE.

Medical Director: The organization must employ, or contract within accordance with 42 CFR 460.70, a medical director who is responsible for the delivery of participant care, for clinical outcomes, and for the implementation, as well as oversight, of the quality improvement program.

Medical Expenses: CalOptima Health PACE's actual expenses incurred and accounted for in accordance with the Generally Accepted Accounting Principles for Covered Services delivered to Members during each period. This includes expenses incurred for provider payment incentive programs, medical management, utilization management and quality assurance activities, but excludes administrative costs as defined in California Code of Regulations title 28, section 1300.78 as well as pass-through items such as intergovernmental transfers, Hospital Quality Assurance Fees, and MCO/Sales taxes.

Medical Loss Ratio (MLR): The Allowed Medical Expenses for the covered services provided to enrollees under the Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by CalOptima Health PACE, by county.

Medical Records: Written documentary evidence of treatments rendered to plan Members.

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.

Member: Any Eligible Medi-Cal Beneficiary who has enrolled in CalOptima Health PACE's plan in accordance with the provisions of California Code of Regulations title 22, section 53420.

Multipurpose Senior Services Program (MSSP): A program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of

comprehensive social and health care management to assist frail elder persons who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.

National Committee for Quality Assurance (NCQA): A non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

NCQA Licensed Audit Organization: An entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

Non-Emergency Medical Transportation: Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per California Code of Regulations title 22, sections 51323, 51231.1 and 51231.2 rendered by licensed providers.

Non-Medical Transportation: Transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated Members by ambulances, litter vans or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations.

Non-Physician Medical Practitioners (Mid-Level Practitioner): A nurse practitioner or Physician assistant authorized to provide Primary Care under Physician supervision.

Not Reported: 1) CalOptima Health PACE calculated the measure, but the result was materially biased; 2) CalOptima Health PACE did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) CalOptima Health PACE calculated the measure but chose not to report the rate.

Nurse: A person licensed by the California Board of Nursing as a Registered Nurse (RN) or Licensed Vocational Nurse (LVN).

Nursing Facility Level of Care: The Level of Care meeting criteria established in the department's approved Medi-Cal Manual of Criteria for Medi-Cal Authorization that includes California Code of Regulations, title 22, sections 51334 and 51335.

On-Call Coverage Services: Telephone coverage by authorized individuals trained to receive calls regarding CalOptima Health PACE Participants Monday through Friday (non-holidays) from 4:30pm to 8:00am the following day, Pacific Standard Time, and Saturdays and Sundays from 8:00am to 8:00am the following Monday, Pacific Standard Time, and all day on CalOptima Health designated holidays that fall on weekdays.

Other Healthcare Coverage Sources (OHCS): The responsibility of an individual or entity, other than CalOptima Health PACE or the Participant, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Participant. Such OHCS may originate under any other State, federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding Tort Liability.

Outpatient Care: Treatment provided to a Member who is not confined in a health care Facility.

Outpatient Mental Health Services: Outpatient services that CalOptima Health PACE will provide for Members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

PACE: Stands for the Program of All-Inclusive Care for the Elderly.

PACE Center: The location designated by CalOptima Health PACE at which Members shall receive services.

PACE at Home: The designation by the PACE Interdisciplinary Team (IDT) for participants who do not have routine day center attendance at the PACE center or Alternative Care Settings (ACS).

PACE Organization: An organization which meets the requirements of 42 CFR Section 460.60, and all other state and federal statutes and regulations applicable to PACE plans and has signed a PACE Program agreement with DHCS.

Participant: An individual enrolled in the CalOptima Health PACE program.

Person-Centered Planning: An ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences.

Physical Restraint: Any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the Participant's body that they cannot easily remove that restricts freedom of movement or normal access to one's body. Examples of physical restraints include special types of vests, chairs with lap trays, lap belts, and enclosed walkers. Bed rails (side rails) are also considered restraints in certain situations.

Physician: A person duly licensed as a Physician by the Medical Board of California.

Physician Incentive Plan: Any compensation arrangement between CalOptima Health PACE and a Physician or a Physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under the DHCS PACE Contract.

Physician Orders for Life-Sustaining Treatment (POLST): A tool for end-of-life planning. It ensures that a patient's treatment wishes are known and will be followed by health care professionals during a medical crisis, when the patient cannot speak for themselves.

Plan of Care: As defined in Title 42, section 460.106 of the Code of Federal Regulations, a comprehensive care plan developed by the interdisciplinary team for each Participant to identify the care needed to meet the medical, physical, emotional, and social needs of the Participant, as identified by comprehensive assessments.

Policy Letter: A document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division (MMCD) or Integrated Systems of Care Division (ISCD) that clarifies regulatory or contractual requirements.

Policy Statement: A detailed goal statement in which CalOptima Health PACE commits to meet all aspects of the DHCS PACE Contract.

Positioning Device: Any device used to align the Participant's body in order to treat a specific medical condition or to meet a specific functional need that does not meet the definition of Physical Restraint. If a positioning device is recommended, a PACE Physician order is not required.

Post-Payment Recovery: CalOptima Health PACE pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

Post Stabilization Care: Services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. These are not emergency services, which CalOptima Health PACE is obligated to pay for, but rather non-emergency services that CalOptima Health PACE should approve before they are provided outside the service area.

Preventive Care: Health care designed to prevent disease and/or its consequences.

Primary Care: A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Dentist: A dentist responsible for supervising, coordinating, and providing dental care to Members.

Primary Care Provider (PCP): A provider 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, such as a Nurse Practitioner or Physician Assistant.

Prior Authorization: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.

Prior Authorization Request: A method by which practitioners seek approval from CalOptima Health PACE to render medical services. The CalOptima Health PACE IDT is responsible for granting approval to providing specific, non-emergency medical services in advance of rendering such services.

Program Director: A person responsible for oversight and administration of the entity as specified by 42 CFR Section 460.60(a).

Protocols: A written plan of delivery of services and must identify how the services are delivered for standard, consistent care to Members.

Provider Appeal: An Appeal concerning the authorization or denial of a service, denial, deferral, or modification of a Prior Authorization request on behalf of a Member or the processing of a payment or non-payment of a claim by CalOptima Health PACE.

Provider Grievance: An oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a provider. DHCS considers complaints and appeals the same as a grievance.

Provider of Services: Any individual, partnership, clinic, group, association, corporation, institution, or public agency meeting applicable standards for participation with the Medi-Cal program as defined in California Code of Regulations title 22, section 51200 et seq.

Quality Improvement (QI): A formal set of activities to assure the quality of clinical and non-clinical services provided. Quality Improvement includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process. Comprehensive Quality Improvement includes mechanisms to assess and assure the quality of both health services and administrative and support services.

Quality Improvement System (QIS): Systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and contract language. CalOptima Health PACE must have processes in place, that measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis.

Quality Incidents: An unexpected occurrence that caused a Member's death or serious physical or psychological injury that included permanent loss of function. Included in this definition are any medical equipment failures that could have caused a death and all attempted suicides.

Quality Indicators: Measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

Quality of Care: The degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge.

Reinsurance: Coverage secured by CalOptima Health PACE, which limits the amount of risk or liability assumed under the DHCS PACE Contract.

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 employee, or a person legally identified in a Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Restraint Release: Removal of a restraint from a Participant with assistance or offer of one (1) or more of the following interventions, as appropriate: toileting, incontinent care, range of motion, ambulation, repositioning, oral hydration, or provision of oral nutrition. CalOptima Health PACE shall Restraint Release utilizing the Restraint Removal Form.

Rural Health Clinic (RHC): An entity defined in California Code of Regulations title 22, section 51115.5.

Safety-Net Provider: Any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety-net providers include FQHCs; governmentally operated health systems; community health centers; Rural and Indian Health Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals.

Screening, Brief Intervention, and Referral to Treatment (SBIRT): Services provided by a PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

Seniors and Persons with Disabilities (SPD): Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the department (See Eligible Beneficiary).

Sensitive Services: Those services related to:

1. Sexually transmitted diseases (STDs)
2. HIV testing

Service Area: The county or counties in which CalOptima Health PACE is approved to operate under the terms of the DHCS PACE Contract. A Service Area may have designated ZIP codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of the DHCS PACE Contract.

Service Location: Any location at which a Member obtains any health care services provided by CalOptima Health PACE under the terms of the DHCS PACE Contract.

Skilled Nursing Facility (SNF): As defined in California Code of Regulations title 22, section 51121(a), any institution, place, building or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home," "convalescent hospital," "nursing home," or "nursing facility".

Specialty Mental Health Provider: A person or entity who is licensed, certified, or otherwise recognized or authorized under State law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service: Those services identified in title 9 California Code of Regulations section 1810.247.

State: The State of California.

Subacute Care: As defined in California Code of Regulations, title 22 section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

Subcontract: A written agreement entered into by CalOptima Health PACE with any of the following:

1. A provider of health care services who agrees to furnish Covered Services to Members; and/or
2. Any other organization or person(s) who agree(s) to perform any administrative function or service for CalOptima Health PACE specifically related to fulfilling CalOptima Health PACE's obligations to DHCS under the terms of the DHCS PACE Contract.

Sub-Subcontractor: Any party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under the DHCS PACE Contract.

Supplemental Security Income (SSI): The program authorized by Title XVI of the Social Security Act (42 U.S.C. §§ 1381-1383f) for aged, blind, and disabled persons.

Telehealth: A method of delivering health care services by using 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 a separate location from the health care provider. Telehealth facilitates Member's self-management and caregiver support for the Member.

Third Party Tort Liability (TPTL): The responsibility of an individual or entity other than CalOptima Health PACE or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal obligation or as a result of, or the fault or negligence of, third parties (e.g., auto accidents, other personal injury casualty claims, or Workers' Compensation Appeals).

Universal/Standard Precautions: A set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. These measures are to be used when providing care to all individuals, whether or not they appear infectious or symptomatic.

Unusual Incident or Injury: One which threatens the welfare, safety, or health of any Member, and which is not consistent with the Center's routine operation or Member care. Any incident that meets the quality incident criteria established by the CMS HPMS reporting guidelines, regardless of where it occurred, must be reported.

Unusual or Seldom-Used Health Care Services: Those services of which twelve (12) or fewer transactions are performed by CalOptima Health PACE in any one-year period.

Urgent Care: On-site services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). Off-site Urgent care, as defined by federal PACE regulation 42 CFR 460.100(e)(3)(ii), means the care provided to a PACE member who is out of the PACE Service Area, and who believes their illness or injury is too severe to postpone treatment until they return to the Service Area, but their life or function is not in severe jeopardy.

Utilization: The rate patterns of service usage or types of service occurring within a specified time. Inpatient Utilization is generally expressed in rates per unit of population-at-risk for a given period, e.g., the number of hospital admissions per 1,000 persons enrolled in an HMO/per year.

Utilization Review: The process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and Facilities.

Working Day(s): State calendar (State Appointment Calendar, Standard 101) working day(s).

III. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	12/01/2014	PA.1000	Glossary of Terms	PACE
Revised	05/01/2016	PA.1000	Glossary of Terms	PACE
Revised	11/01/2017	PA.1000	Glossary of Terms	PACE
Revised	07/01/2018	PA.1000	Glossary of Terms	PACE
Revised	01/01/2020	PA.1000	Glossary of Terms	PACE
Revised	03/01/2021	PA.1000	Glossary of Terms	PACE
Revised	07/01/2022	PA.1000	Glossary of Terms	PACE
Revised	10/01/2023	PA.1000	Glossary of Terms	PACE
Revised	09/01/2024	PA.1000	Glossary of Terms	PACE