Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.
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SECTION 35.0: OVERVIEW

OVERVIEW

Program Summary

The Program of All-Inclusive Care for the Elderly (PACE) is an optional service under the Medicaid State plan. PACE is a capitated, managed care program, with objectives to:

- Enhance the quality of life and autonomy for frail, older adults;
- Enable frail elderly individuals to live independently in the community, rather than be institutionalized, as long as medically and socially feasible;
- Maximize the dignity and respect for older adults; and
- Preserve and support the older adult’s family unit.

In order to meet program requirements, a PACE recipient must:

- Be at least 55 years of age or older;
- Live in the approved PACE provider service area;
- Meet the requirement for Medicaid eligibility;
- Be certified by the state to need nursing facility level of care; and
- Be able to live in the community with PACE support without jeopardizing health and safety.

The PACE organization must provide comprehensive health care services based on his or her individual needs with the goal of enabling individuals to continue living independently in the community. PACE must coordinate and provide all needed preventative, primary health, acute and long term care services. The PACE organization must establish and implement a written Plan of Care to furnish care that meets the needs of each recipient in all care settings 24 hours a day, every day of the year.

The PACE program includes all Medicare and Medicaid covered services and other services determined by the PACE interdisciplinary team (IDT) necessary to maintain or restore the PACE recipients independence to remain in their homes or communities. The PACE recipient must
receive all of their services through the PACE organization.

PACE providers assume full financial risk for the recipient’s care without limits on amount, duration, or scope of services. PACE is responsible for all care costs, even if it exceeds the monthly capitated payment they receive each month from Medicare and/or Medicaid.

**Background Information**

PACE model of care is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. In the early 1970s a nonprofit corporation, On Lok Senior Health Services, was formed to create a community-based system of care that consisted of a comprehensive system of care combining housing and all necessary medical and social services was outlined. The model was tested through Centers for Medicare and Medicaid Services (CMS), then Health Care Financing Administration (HCFA), demonstration projects that began in the mid 1980s. For most recipients, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized.

The Balanced Budget Act of 1997 (BBA) established PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs and mandated that the quality of care be monitored. This enabled states to provide PACE services to Medicaid beneficiaries as a Medicaid State plan option. In 2004 Louisiana included PACE as an optional benefit in the Medicaid program.

**Purpose of this Chapter**

The Department of Health and Hospitals (DHH), Office of the Secretary, Bureau of Health Services Financing (BHSF), Office of Aging and Adult Services (OAAS) implements the PACE program in accordance with the federal regulations in Title 42 Part 460 of the Code of Federal Regulations (CFR) and the Louisiana Administrative Code, Title 50, part XXIII. This Louisiana Medicaid Manual Chapter is intended to assist the provider in understanding and correctly implementing federal and state PACE policies and procedures.

The services offered under the PACE program are provided by a Medicaid enrolled agency that has a valid Adult Day Health Care (ADHC) license issued by DHH, BHSF, Health Standards Section (HSS) in accordance with the State of Louisiana licensing requirements for ADHC.
SERVICES

The Program of All-Inclusive Care for the Elderly (PACE) organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders to maintain independence in the home and/or community for as long as possible.

Service Definitions

The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the PACE interdisciplinary team (IDT) to improve and maintain the recipients overall health status. As specified in 42 Code of Federal Regulations (CFR) 460.98(c) services must include, but are not limited to, the following:

- Primary care services, including physician and nursing services;
- Social work services;
- Restorative therapies, including physical therapy, occupational therapy;
- Personal care and supportive services; and
- Nutrition counseling.

Service Limitations

The PACE organization becomes the sole service provider for Medicaid recipients who enroll in a PACE organization. PACE recipients must use the PACE organization’s physician and provider network for all health services.

PACE provides an IDT, consisting of professional and paraprofessional staff, employed or contracted, to comprehensively assess each individual to determine necessary services and to case manage care and services provided to PACE recipients. The frequency of a recipient’s attendance at the PACE center is determined by the IDT, based on the needs and preferences of each recipient.

In accordance with 42 CFR 460.96, the services that are excluded from coverage under the PACE program are as follows:

- Any service that is not authorized by the IDT, even if it is listed as a required service, unless it is an emergency service as specified in 42 CFR 460.100;
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- Inpatient facility services for private room and private duty nursing services, (unless medically necessary) and non-medical items for personal convenience such as telephone, radio or television rental, (unless specifically authorized by the IDT as part of the recipient’s Plan of Care);

- Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following a mastectomy;

- Experimental medical, surgical, or other health procedures; and

- Services furnished outside of the United States except as follows:
  - In accordance with CFR 424.122 and 424.124; and
  - As permitted under the State’s approved Medicaid plan.

The PACE organization must inform potential recipients that they offer Medicare Part D prescription drug coverage. Recipients must be informed that if they are in a PACE program they cannot enroll in a separate Medicare prescription drug plan. Joining a separate Medicare drug plan will cause the potential PACE recipient to lose their PACE health and prescription drug benefits.

PACE program provides comprehensive care to recipients who need end-of-life care. If a recipient chooses to elect the hospice benefit from a certified hospice organization the recipient must voluntarily disenroll from the PACE program.

Service Delivery

The PACE program agreement must define its service area. This service area must be approved by Centers for Medicare and Medicaid Services (CMS) and Office of Aging and Adult Services (OAAS). CMS and OAAS must approve any change in the designated service area as required by 42 CFR 460.32(a) (1). CMS, in consultation with OAAS, may exclude from the designation an area that is already covered under another PACE program agreement to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program (as specified in 42 CFR 460.22). The CMS and OAAS approved Louisiana PACE service areas are designated by parish or zip code.
The PACE organization must establish and implement a written Plan of Care that meets the needs of each recipient in all care settings 24 hours a day, every day of the year as specified in 42 CFR 460.98. These services must be furnished in at least the PACE center, home, inpatient facilities, and other referral service settings that the recipient may need. This does not change an individual’s PACE enrollment status or the capitation rate. The PACE organization shall be responsible for payment of the cost of the care in any setting.

A PACE recipient may need temporary or permanent placement in another health care setting and enter a nursing facility that has a contract with the PACE organization. The PACE organization must establish and implement a written Plan of Care to furnish care that meets the needs of the recipient in the nursing facility. There must be coordination of care between the PACE organization and the nursing facility, during the recipient’s placement in the nursing facility.

The PACE organization must notify OAAS Nursing Facility Admission or its designee of the nursing facility placement. A Level I Pre-Admission Screening and Resident Review (PASRR) is required before a PACE recipient is transferred to a nursing facility. The PACE physician shall complete the Level I PASRR. It must be documented on the front page of the PASRR that a PACE recipient is entering the nursing facility. If the Level I PASRR indicates mental illness or developmental disability the case will be referred to the Level II authority, the Office of Behavioral Health or the Office for Citizens with Developmental Disabilities, for final determination. A Louisiana Level of Care Eligibility Tool (LOCET) is not required when a PACE recipient enters a nursing facility.
RECIPIENT REQUIREMENTS

Recipient Criteria

As required by 42 Code of Federal Regulations (CFR) 460.150, the applicant must meet all of the following criteria to be eligible to enroll in a Program of All-Inclusive Care for the Elderly (PACE) program:

- Must be at least 55 years of age or older;
- Live in the approved geographic area of the PACE organization (designated by parish or zip code);
- Meet the requirement for Medicaid financial eligibility;
- Meet nursing facility level of care requirements; and
- At the time of enrollment the recipient must be able to reside safely in a community setting with PACE support.

The PACE organization must conduct a comprehensive health and safety assessment at the time of enrollment to ensure that the applicant’s health, safety, or welfare will not be jeopardized by living in the community. The assessment must include:

- An on-site evaluation visit(s) of the applicant’s place of residence;
- An evaluation of whether the applicant can be safely transported to the PACE center;
- If the individual is able to live safely alone, is there a primary caregiver at home, or willingness to use another caregiver or provider to meet the individual’s needs;
- If hygiene, nutrition, medical care, and support systems adequate;
- If behavioral problems exist, can they be managed to prevent risk to self or others; and
- If the Plan of Care can be developed to meet the individual needs.
Medical Necessity

To enroll in a PACE program potential recipients must be determined to need the nursing facility level of care as required under the Medicaid State plan for coverage of nursing facility services as specified in 42 CFR 460.152(a) (3). The Louisiana Level of Care Eligibility Tool (LOCET) is the pre-enrollment screening tool used to determine if the applicant meets nursing facility level of care. Applicants applying for PACE services are screened for nursing facility level of care by use of the LOCET that is completed over the telephone by Office of Aging and Adult Services (OAAS) or its designee. The LOCET is completed by calling the toll-free telephone number maintained by the OAAS designated contracted agency. At the time of the LOCET screening individuals are informed of other available program options to assure freedom of choice.

A LOCET is not required if the PACE applicant has an approved LOCET in the OAAS system data base that was performed within the previous 12 months. If the PACE applicant has no such LOCET in the OAAS system data base, the OAAS designated contracted agency must conduct a telephone LOCET in order to determine if the applicant meets nursing facility level of care criteria.

In addition to the LOCET screening determination, every PACE applicant must receive a face-to-face Minimum Data Set-Home Care (MDS-HC) assessment prior to enrollment to verify that the applicant continues to meet the required nursing facility level of care criteria for enrollment in PACE. The PACE staff must schedule an initial face-to-face MDS-HC assessment prior to enrollment. The MDS-HC assessment shall be completed only by OAAS MDS-HC trained and certified PACE staff. The face-to-face MDS-HC determination will override the telephone LOCET screening determination.

If the initial MDS-HC does not meet nursing facility level of care the PACE organization must notify the OAAS Regional Office who shall make the final determination regarding the applicant’s medical and functional eligibility.
How to Access Services

The Program of All-Inclusive Care for the Elderly (PACE) applicant/representative must call the PACE organization located in his/her geographical area or the toll-free telephone number to the Office of Aging and Adult Services (OAAS) designated contract agency and request a Louisiana Level of Care Eligibility Tool (LOCET) to be completed. The telephone LOCET is a level of care pre-enrollment screening tool that is completed by the OAAS designated contracted agency.

Authorization Process

The PACE authorization process includes the following intake process as specified in 42 CFR 460.152(a):

- The PACE staff must explain to the potential recipient and his/her representative or caregiver the following information:
  - PACE organization, using a copy of the PACE Enrollment Agreement specifically references the elements of the agreement;
  - The requirement that the PACE organization would be the recipient’s sole service provider and clarification that the PACE organization guarantees access to services, but not a specific provider;
  - A list of the employees of the PACE organization who furnish care and the most current list of contracted health care providers under 42 CFR 460.70(c);
  - Monthly premiums, if any;
  - Any Medicaid spenddown obligations; and
  - Post-eligibility treatment of income.
• The potential recipient must sign a release to allow PACE the organization to obtain his/her medical and financial information and eligibility status for Medicare and Medicaid.

• PACE staff must assess the potential recipient to ensure that he/she can be cared for appropriately in a community setting and meets all requirements for PACE eligibility. The criteria used to determine if the individual’s health and safety would be jeopardized by living in the community setting must be specified in the program agreement in accordance with 42 CFR 460.150 (c) (2).

When an enrollment is denied, because the PACE applicant’s health or safety would be jeopardized by living in the community setting, the PACE organization must meet the following requirements as specified by 42 CFR 460.152(b):

• Notify the individual in writing of the reason for enrollment denial;

• Refer the individual to alternative services as appropriate;

• Maintain supporting documentation of the denial;

• Make the documentation available for review;

• Notify Centers for Medicare and Medicaid Services (CMS) and OAAS through the reporting of the Data Elements in monitoring in CMS’ Health Plan Management System (HPMS) and make documentation available for review; and

• The PACE organization must submit proposed denial of enrollment determinations of applicants for health and safety reasons for review prior to notifying applicants of such adverse decisions. OAAS RO must review denials of PACE enrollment eligibility in a timely manner.

As required by 42 CFR 460.154, each applicant enrolling in PACE must accept the PACE organization and its provider network as the sole provider of services. This requirement must be included in the PACE Enrollment Agreement. The applicant or his/her designated representative must sign and date an enrollment agreement that contains, at a minimum, the following:

• Mission and philosophy;
Eligibility criteria;  
Enrollment and disenrollment procedures;  
Recipient rights and responsibilities;  
Benefits and coverage;  
Multidisciplinary care team;  
Consumer advisory committee;  
Contract providers;  
Emergency and urgent care;  
Out-of-service-area coverage;  
Prescription drug coverage;  and  
Grievance and appeals procedures.

As specified in 42 CFR 460.156, the PACE organization must give a recipient, upon signing the PACE Enrollment Agreement, the following:

- A PACE membership card;  
- A copy of the PACE Enrollment Agreement;  
- Emergency information to be posted in his/her home identifying the individual as a PACE recipient and explaining how to access emergency services; and  
- Stickers for the recipient’s Medicaid card, as applicable, which indicate that he or she is a PACE recipient and which include the phone number of the PACE organization.
The PACE interdisciplinary team (IDT) must conduct an initial in-person comprehensive assessment of each recipient. The information obtained through the recipient assessment is the basis for the Plan of Care developed by the IDT. The assessment must be as comprehensive as possible in order to capture all of the information necessary for the IDT to develop a Plan of Care that will adequately address all of the recipient’s functional, psychosocial and health care needs. The assessment process begins before enrollment, when the PACE organization evaluates whether a potential PACE recipient can be cared for appropriately in the program. The comprehensive assessment is often accomplished by the effective date of enrollment, but shall never be delayed more than a few days beyond that date.

The PACE applicant must receive a face-to-face Minimum Data Set-Home Care (MDS-HC) assessment prior to enrollment to verify that the applicant continues to meet the required nursing facility level of care criteria for enrollment in PACE. The MDS-HC must be completed by OAAS trained and certified PACE staff. If the initial MDS-HC assessment determined the applicant does not meet nursing facility level of care the PACE organization must notify the OAAS RO to request review of all enrollment data, including the MDS-HC. The OAAS RO will ensure the accuracy of the enrollment data and make the final determination regarding nursing facility level of care. OAAS RO shall be responsible for assuring that all avenues of eligibility have been explored prior to determining that an individual does not meet the required nursing facility level of care. OAAS RO shall notify the PACE organization of the final determination.

When an enrollment is denied the PACE organization must notify CMS and the SAA through the Data Elements in Health Plan Management System (HPMS).

When a PACE applicant request transition from a waiver program to the PACE program the OAAS trained and certified PACE staff will complete a hard copy of the initial MDS-HC assessment. The OAAS RO will be notified of the completed MDS-HC assessment. The OAAS RO will enter the hard copy MDS-HC assessment into the OAAS database. The OAAS RO will send the PACE organization a computer generated copy of the MDS-HC and notify the PACE organization of the MDS-HC results.

Once medical and functional eligibility and program requirements have been established as being met the PACE organization must submit all enrollment data to the OAAS Regional Office (RO). The Louisiana Department of Health and Hospitals Medicaid Program Notice of Medical Certification (Form 142) is generated and submitted to the Parish Medicaid Office by the OAAS RO. The issuance of this by OAAS RO ensures that the PACE recipient has met medical and functional eligibility for PACE. The Parish Medicaid Office must determine financial eligibility. The PACE applicant is not officially enrolled until the PACE organization receives the Form 18P from the Parish Medicaid Office. The issuance of Form18P ensures that the PACE recipient is financially eligible.
The recipient’s effective date of enrollment is on the first day of the calendar month following the date the PACE organization receives the recipient’s signed PACE Enrollment Agreement as specified in 42 CFR 460.158. The recipient is enrolled for the next year unless the recipient either decides to voluntarily disenroll or is involuntarily disenrolled or in death in accordance with 42 CFR 460.160(a).

Changing Providers

The recipient may request voluntary disenrollment for the purpose of reinstatement into other Medicare and Medicaid programs for which the recipient is eligible as specified in 42 CFR 460.168.

The PACE organization must take the following actions to assist the recipient:

- Make appropriate referrals and ensure medical records are made available to new providers in a timely manner; and
- Work with CMS and OAAS to reinstate the recipient in other Medicaid programs for which the recipient is eligible.

No disenrollment will become effective until the recipient is appropriately reinstated into other Medicare and Medicaid programs for which the recipient is eligible and alternative services are arranged. The recipient must continue to use PACE organization services and remain liable for any premiums until the date of enrollment is terminated.
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SECTION 35.4: PROVIDER REQUIREMENTS

PROVIDER REQUIREMENTS

Provider Certifications/Recertification Requirements

The State Readiness Review, developed by Centers for Medicare and Medicaid Services (CMS), is used by the State Administering Agency (SAA) to perform the readiness review of non-operational Program of All-Inclusive Care for the Elderly (PACE) organization applicants prior to enrolling recipients. The SAA must conduct an assessment of provider readiness prior to operation. The SAA reviews the PACE organizations policies and procedures, the design and construction of the building, emergency preparedness, compliance with Occupational Safety and Health Administration (OSHA), Food and Drug Administration (FDA), state and local laws and life safety codes. For the non-operational PACE programs CMS and the SAA shall conduct a site review within six months of the provider enrolling its first recipient.

As required by 42 Code of Federal Regulations (CFR) 460.190, CMS and SAA must conduct comprehensive annual reviews of PACE organizations during the trial period of review, the first three years of operation, to ensure compliance with the PACE regulation. After the initial three year period, reviews shall be conducted by CMS and State, including an on-site visit at least every two years, in accordance with 42 CFR 460.192.

CMS and the SAA report the results of the reviews to the PACE organization, along with any recommendations for changes to the organization’s program. The PACE organization must write a corrective action plan (CAP), a description of the action plan that will be taken to correct the identified deficiency. Disclosure of the review results must be available as demonstrated in 42 CFR 460.196.

Accreditation, Licensure, Other Applicable Standards for Participation

The PACE organization must be enrolled in the Medicaid program and hold a Medicaid provider agreement/provider number as a PACE provider. PACE is a Medicaid State plan service; not a waiver service. PACE will not be enrolled in the Medicaid program as an Adult Day Health Care (ADHC).

In an exception, the PACE organization shall be licensed by the Health Standards Section (HSS) as an ADHC facility. HSS shall grant appropriate waivers of ADHC licensing requirements in instances where ADHC licensing regulations conflict with PACE requirements when such waivers are determined to have no adverse effect on recipient health and safety and quality of life.

In an exception to the State of Louisiana licensing requirement for ADHC, a center shall not admit more clients into care than the number specified on their license. PACE may enroll more
people in PACE than the license for ADHC will allow, but shall not exceed the licensed capacity on any day.

In an exception to the licensing requirement for ADHC an individual who has not attended a center at least 36 days each quarter (every 3 months) shall not be eligible for ADHC services. A PACE recipient may have supports at their home during the day and may not need the daily support provided by the ADHC component of PACE. The frequency of a recipient’s attendance at the center is determined by the PACE interdisciplinary team (IDT) based on the needs and preferences of the recipient in accordance with 42 CFR 460.98(e). The recipient may not attend the center within 36 days per quarter period. The recipient must not be disenrolled from PACE.

Provider Responsibilities

The following characteristics must apply:

- Must be operating under the control of an identifiable governing body that includes at least one recipient representative, as specified in 42 CFR 460.62(a) with full legal authority and responsibility for:
  - Governance and operation of the organization;
  - Development of policies consistent with mission;
  - Management and provision of all services, including the management of contractors;
  - Establishment of personnel policies that address adequate notice of termination by employees or contractors with direct patient care responsibilities;
  - Fiscal operation;
  - Development of policies on recipient health and safety, including a comprehensive systemic operational plan to ensure the health and safety of recipients; and
  - Quality Assessment and Performance Improvement (QAPI) program (with the purpose of linking the development, implementation, and coordination of the ongoing QAPI program with all aspects of the PACE program).
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SECTION 35.4: PROVIDER REQUIREMENTS

- Be able to provide the complete service package regardless of frequency or duration of services;

- Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals as specified in 42 CFR 460.98(c);

- Have a defined service area;

- Have safeguards against conflict of interest, as defined in 42 CFR 460.68;

- Have demonstrated fiscal soundness, as defined in 42 CFR 460.80 and 42 CFR 460.208;

- Have a formal Recipient Bill of Rights, as defined in 42 CFR 460.110 and 42 CFR 460.112; and

- Have a process to address grievances and appeals.

The following advisory committees must also be established to advise the governing body:

- Recipient Advisory Committee must provide advice to the governing body on matters of concern to recipients. Recipients and representatives of recipients (his/her care giver) shall constitute a majority of the membership. The committee must provide the liaison to the governing body to present issues from the recipient advisory committee in accordance with 42 CFR 460.62(b);

- Ethics Committee; and

- Other committees as required by CMS and/or SAA.

The PACE organization must not discriminate against any recipient in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, mental, or physical disability or source of payment.

The PACE organization must establish, implement, and maintain a documented infection control plan that meets the requirements as specified in 42 CFR 460.74. The PACE organization must follow accepted policies and standard procedures with respect to infection control, including at least the standard precautions developed by the Centers for Disease Control and Prevention.
The PACE organization must have a current organizational chart in accordance with 42 CFR 460.60. The PACE organization planning a change in organizational structure must notify CMS and the SAA, in writing, at least 14 days before the change takes effect.

The PACE organization is required to establish, implement, and maintain a documented marketing plan with measurable enrollment objectives and a system to track effectiveness as described in 42 CFR 460.82. All marketing material, including any initial, revised or updated marketing material, must be reviewed and approved by CMS and SAA.

As required by 42 CFR 460.116 the PACE organization must have written polices and implements procedures to ensure that the explanation of rights to the recipient, his or her representative, and staff are fully explained and understood. The PACE organization must have established documented procedures to respond to and rectify a violation of a recipient’s rights in accordance with 42 CFR 460.118. The PACE organization must limit the use of chemical or physical restraints to the least restrictive method as described in 42 CFR 460.114.

In accordance with 42 CFR 460.72 the PACE organization must have a written plan and procedure for handling emergency situations. At least annually the PACE organization must test, evaluate, and document the effectiveness of its emergency and disaster plans to ensure and maintain appropriate responses to situations and needs from both medical and non-medical emergencies. The PACE organization must have a documented plan to obtain emergency medical assistance from sources outside the center when needed.

The minimum emergency equipment that must be available for use at each PACE center includes easily portable oxygen, airways, suction, and emergency drugs, along with staff on the premises at all times who know how to use the equipment. The PACE organization must establish, implement and maintain a written plan to ensure that all equipment is maintained in accordance with manufacturer’s recommendations.

The PACE organization must maintain owned, rented, or leased transportation vehicles in accordance with manufacturer’s recommendations. If a contractor provides transportation services the PACE organization must ensure that the vehicles are maintained in accordance with manufacturer’s recommendations.

If there are changes in the PACE Enrollment Agreement information at any time during the recipient’s enrollment, the PACE organization must:

- Give an updated copy of the information to the recipient; and
- Explain the changes to the recipient and his or her representative or caregiver in a manner they understand.
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SECTION 35.4: PROVIDER REQUIREMENTS

A PACE organization must only involuntarily disenroll a PACE recipient from the PACE program, in accordance with 42 CFR 460.164, for the following reasons:

- If a recipient fails to pay, or make satisfactory arrangements to pay, any premium due the PACE organization after a 30 day grace period;

- The recipient engages in disruptive or threatening behavior;

- The recipient moves out of the PACE service area or is out of the service area for more than 30 days, unless the PACE organization agrees to a longer absence due to extenuating circumstances;

- The PACE program agreement with CMS and Office of Aging and Adult Services (OAAS) is not renewed or is terminated;

- The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers; and

- The recipient is determined no longer to meet Medicaid state nursing facility level of care requirements and is not deemed eligible. The PACE organization must make the determination that the recipient no longer meets level of care and would not reasonably be expected to become eligible for PACE services within 6 months in the absence of continued coverage under the PACE program.

The following behaviors are behaviors considered disruptive or threatening behaviors for purposes of involuntary disenrollment as specified by 42 CFR 460.164(b) (1&2):

- The behavior that jeopardizes his/her health or safety, or the safety of others; and

- Consistent refusal to comply with his/her individual plan of care or the terms of the PACE enrollment agreement by a recipient with decision making capacity, but not if the behavior is related to a mental or physical condition of the recipient. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

Under the authority of Section 903 of the Benefits Improvement and Protection Act (BIPA), as noted in 42 CFR 460.26, a PACE organization must have a CMS approved waiver to expand the request to involuntarily disenroll a recipient. This is a request typically made at the time of program development.
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- The ability to disenroll a recipient for behaviors or actions taken by the recipient’s family or care giver that renders the recipient noncompliant, as specified in 42 CFR 460.164(d); and

- The recipient who is permanently placed in a nursing facility fails to pay or to make satisfactory arrangements to pay, the amount of patient liability that would be required to be paid by a Medicaid eligible resident of a nursing facility if he/she was not a recipient in a PACE organization.

The PACE organization must document reasons for the involuntary disenrollment and all efforts to resolve the problem. Involuntary disenrollment shall occur only after all attempts at resolving the issues have been exhausted. The PACE organization must submit all documentation used to support the involuntary disenrollment to the Office of Aging and Adult Services Regional Office (OAAS RO) in accordance with 42 CFR 460.164(e).

The OAAS RO shall submit their preliminary determination to approve/deny the involuntary disenrollment to the OAAS State Office (SO) PACE program designated contact person within 3 business days of receipt of all supportive documentation from the PACE organization. The final justification to proceed with disenrollment will be determined by the OAAS SO within two business days of receipt of the OAAS RO preliminary determination and supporting documentation. OAAS SO shall notify OAAS RO of the final determination if involuntary disenrollment is approved by OAAS SO. The PACE organization shall be notified by the OAAS RO within one business day of receipt of the final determination from OAAS SO.

As specified in 42 CFR 460.160(b), an annual MDS-HC recertification assessment must be completed to reevaluate whether the recipient continues to meet level of care required under the state Medicaid plan for coverage of nursing facility services. The PACE applicant must receive a face-to-face Minimum Data Set-Home Care (MDS-HC) assessment by OAAS trained and certified PACE staff to verify that the applicant continues to meet the required nursing facility level of care criteria for enrollment in PACE.

In accordance with 42 CFR 460.160(b) (2), OAAS may determine that a PACE recipient, who no longer meets the State Medicaid nursing facility level of care requirements, may be deemed to continue to be eligible for the PACE program until the next annual reevaluation. The PACE organization may request “deemed continued eligibility” based on the following criteria:

- The recipient no longer meets the nursing facility level of care criteria but would reasonably be expected to become eligible within six months in the absence of continued coverage under the program; and
• The recipient’s medical record and plan of care support deemed continued eligibility.

The PACE organization must submit the request for Deemed Continued Eligibility Form (OAAS-PF-10-002) to the OAAS RO within five business days of notification of a PACE recipient not having met nursing facility level of care.

The PACE IDT must submit a brief justification summary and supporting documentation from the recipient’s medical record/Plan of Care that supports the request for Deemed Continued Eligibility Form (OAAS-PF-10-002). Supporting documentation includes any information that, in the absence of PACE services, the recipient would reasonably be expected to experience a decline in functional abilities or health to a degree that he/she would meet nursing facility level of care criteria within six months.

Examples of supporting documentation include, but are not limited to:

• Diagnosis of a chronic, and/or disabling condition;

• Physician and/or nursing progress notes documenting the treatment and impact of same on chronic, and/or disabling condition(s);

• Physician’s Orders and a list of services currently provided to the recipient (e.g. physical therapy, occupational therapy, dietary management, blood pressure checks, etc.); and

• Frequency of medical appointments and/or frequency of medical treatments/interventions that point to unstable medical condition that must be treated, and or monitored to avoid complications.

OAAS RO shall review all documentation and respond within 10 business days upon the receipt of the request and all supporting documentation. OAAS RO may request an onsite visit to meet with the recipient, conduct its own level of care assessment and/or request additional information. The PACE organization must submit the requested information no later than 5 business days from the date of receipt of OAAS’ request for the additional information. If OAAS does not receive the requested information within the five business days, OAAS shall proceed with the denial process.
The PACE organization will be notified in writing via the Deemed Continued Eligibility Form (OAAS-PF-10-002) if the OAAS RO deems continued eligibility and enrollment will continue until the next annual reassessment.

OAAS RO shall make a notation in the MDS-HC Notebook that deemed continued eligibility criteria met on -------- (date goes in the blank space) for continuation of PACE program until next annual MDS-HC reassessment.

The PACE organization shall continue to conduct annual MDS-HC reassessments for level of care and may request Deemed Continued Eligibility each year as appropriate.

**Staffing Requirements**

A PACE organization must have the ability to manage the comprehensive care (including acute and long term) of a complex nursing facility eligible population 365 days a year, 24 hours per day, seven days per week regardless of the setting. A PACE organization must develop a provider network in order to provide/contract for all required covered services and other services necessary to meet recipient needs.

As specified in 42 CFR 460.68, the PACE organization must not employ individuals, contract with organizations or individuals who have been:

- Excluded from participation in the Medicare and Medicaid programs;
- Convicted of Medicare, Medicaid, or other health insurance or health care programs, or any social service program related crimes; and
- Convicted of physical, sexual, drug or alcohol abuse in a capacity where an individual’s contact with recipients would pose a potential risk.

As required by 42 CFR 460.71, the PACE organization must develop a program to ensure that staff and contractors furnishing direct recipient care services:

- Comply with any state or federal requirements for direct patient care staff in their respective settings;
- Be currently certified, licensed or registered to practice in the state in which they provide services;
Demonstrated competency prior to performing direct recipient care;

Have one year of experience with a frail or elderly population; and

Be medically cleared for communicable diseases and have all immunizations up-to-date before engaging in direct recipient contact.
STAFFING AND TRAINING

Staff Qualifications

Each member of the Program of All-Inclusive Care for the Elderly (PACE) organization’s staff that has direct recipient contact (employee or contractor) must have a minimum of 1 year experience working with a frail or elderly population and meet the staffing requirements as specified in 42 Code of Federal Regulations (CFR) 460.71. In addition to the staffing requirements the PACE interdisciplinary team (IDT) must also include, but not limited to, the following qualifications:

- Primary care physician (PCP) must meet additional qualifications and conditions, as defined in 42 CFR 410.20;

- Social worker must have a master’s degree in social work from an accredited school of social work;

- Dietitian must have a bachelor of science degree or advanced degree from an accredited college with major studies in food and nutrition or dietetics;

- Registered nurse (RN) must be a graduate of a school of professional nursing;

- Physical therapist (PT) must be a graduate of a physical therapy curriculum approved by the American Physical Therapy Association, the Committee on Allied Health Education and Accreditation of the American Medical Association, or the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or other equivalent organizations approved by Centers for Medicare and Medicaid Services (CMS);

- Occupational therapist (OT) must be a graduate of an occupational therapy curriculum accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association or other approved equivalent organization, be eligible for the National Registration Examination of the American Occupational Therapy Association, have 2 years experience as an OT and have achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except for the proficiency does not
apply to persons initially licensed by a state or seeking initial qualification as an OT therapist after December 31, 1977; and

- Transportation driver must have a valid driver’s license to operate a van or bus in the state of operation and have the ability and experience in transporting individuals with special mobility needs.

**Staff Responsibilities**

The PACE organization must employ, or contract in accordance with 42 CFR 460.70, the following:

- Program director who is responsible for oversight and administration of the entity; and

- Medical director who is responsible for the delivery of recipient care, for clinical outcomes, and the implementation, as well as oversight, of the Quality Assessment and Performance Improvement (QAPI) program.

A PACE organization must comply with 42 CFR 460.102, to establish an 11 member IDT at each PACE center. Each recipient must be assigned to an IDT at the PACE center that the recipient attends. The IDT is responsible for conducting health assessments, care planning, and coordination of 24 hours care delivery.

The IDT members may be employed or contracted staff. If the PACE organization uses contracted staff they must meet the same personnel requirements and perform the same responsibilities as employed IDT members.

The PACE IDT must include, at a minimum, the following members:

- Primary care physician;

- Registered nurse;

- Physical therapist;

- Occupational therapist;

- Recreational therapist or activity coordinator;
• Masters level social worker;

• Personal care attendant (PCA) or his or her representative;

• Dietitian;

• Transportation driver or his or her representative;

• PACE center supervisor/manager; and

• Home care liaison/coordinator.

Mid-level practitioner(s) may be used to supplement the physician’s care to recipients, within the scope of practice authorized by the state, by assisting the physician with the delivery of clinical care. They may participate but must not replace the physician on the IDT or perform recipient assessments/reassessments.

The PACE IDT must conduct an initial in-person comprehensive assessment as described in 42 CFR 460.104(a) and periodic in-person reassessments as described in 42 CFR 460.104(c) (d). Recipient unscheduled reassessments by the IDT must be completed when there is a significant change in health or psychosocial status and the recipient or his/her designated representative believes that the recipient needs to initiate, eliminate, or continue a particular service. The IDT members must meet to consolidate the findings into the care plan.

The IDT members that must conduct the initial in-person assessment or an unscheduled reassessment include the primary care physician, registered nurse, master’s level social worker, physical therapist, occupational therapist, recreational therapist, dietitian, and home care coordinator. The IDT may identify other healthcare specialists that are required to conduct additional assessments outside of the IDT members’ expertise or scope of practice.

The IDT primary care physician, registered nurse, master’s level social worker, and recreational therapist/activity coordinator must all conduct periodic health reassessments at least every 6 months and more often if the recipient’s condition dictates. Other IDT members or specialty practitioners actively involved in the recipient's care plan must also be included.

The physical therapist, occupational therapist, dietitian, and home care coordinator, at a minimum must conduct, at least on an annual basis, an in-person reassessment. Other IDT members or specialty practitioners actively involved in the recipient’s care plan must also be included.
The IDT must promptly develop the comprehensive Plan of Care for each recipient after completing the assessments as specified in 42 CFR 460.106. The IDT must implement, coordinate and monitor the Plan of Care whether the services are furnished by PACE staff or contractors. The team must collaborate with the recipient or caregiver, or both, to ensure there is agreement with the Plan of Care and that the recipient’s concerns are addressed. The IDT must continuously monitor the recipient’s health and psychosocial status, as well as the effectiveness of the Plan of Care through the provision of services, informal observation, input from the recipients or caregivers, and communications among members of the IDT and other providers. On at least a semi-annual basis, the IDT must reevaluate the Plan of Care, define outcomes and make revisions as necessary. Anytime there is a significant change in health status the Plan of Care must be updated. The PACE staff (employees and contractors), as part of the IDT process, must communicate relevant changes in a recipient’s care plan to transportation personnel as required by 42 CFR 460.76(e).

The PACE applicant must receive a face-to-face Minimum Data Set-Home Care (MDS-HC) assessment initially and then annually to verify that the applicant continues to meet the required nursing facility level of care criteria for enrollment in PACE. The MDS-HC must be completed only by OAAS MDS-HC trained and certified PACE staff.

The PACE organization must designate an individual to coordinate and oversee implementation of the quality assessment and performance improvement activities as specified in 42 CFR 460.136(b). The quality improvement coordinator must encourage PACE recipients and caregivers to be involved in quality assessment and performance activities, including information about their satisfaction with services.

The PACE organization must designate a staff member to ensure that all PACE staff furnishing care directly to recipients demonstrate the skills necessary for performance of their position. The designated staff person must oversee the orientation program and competency evaluation program for employees and work with PACE contracted liaison to ensure compliance in accordance with 42 CFR 460.71(a) (4).

**Orientation and Training**

The PACE organization must provide to staff (employees and contractors) with an orientation that includes, at a minimum, the organization’s mission, philosophy, practices and protocols of the PACE organization, policies on recipient’s rights, emergency plan, ethics, the PACE benefit, and any policies related to job duties of specific staff.

In addition the orientation must include but not limited to:

- Organizational chart;
A PACE organization must develop a competency evaluation program that identifies those skills, knowledge and abilities that must be demonstrated by all direct recipient care staff as specified in 42 CFR 460.66(a). The competency program must be evidenced as completed before performing personal care services independently and on an on-going basis. Certification of satisfactory completion of the competency program must be in the personnel files of all employees and contracted staff.

In accordance with 42 CFR 460.66 (b) & (c) the PACE organization must develop a training program for each employed and contracted PCA. The skills of each PCA must be evaluated upon hire to establish a baseline competency before providing personal care services independently. A training plan must be specific to the competencies and deficiencies demonstrated.

OSHA training must be provided on hire and annually by a qualified trainer. This training must be given in an interactive session with a trainer present.
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SECTION 35.5: STAFFING AND TRAINING

The PACE staff (employees and contractors) must be trained on the PACE organization’s grievance and appeals processes.

The PACE organization must provide emergency training and periodic orientation to all staff (employees and contractors) and recipients to ensure knowledge of emergency procedures, including informing recipients what to do, where to go, and whom to contact in case of an emergency. The PACE organization must have at least one staff member trained in cardiopulmonary resuscitation (CPR) during the hours the recipients are in the PACE center.

The PACE organization must train all transportation personnel (employees and contractors) in managing the special needs of recipients, how to and types of issues to communicate to the PACE center staff about recipients, and in handling emergency situations as described in 42 CFR 460.76(d).

The PACE organization must provide on-going training to maintain and improve the skills and knowledge of all PACE personnel (employee and contracted staff). The annual training must be related to specific positions which include relevant topics. The training needs to be staggered throughout the year to enable all staff to participate. The training program needs to describe plans for in-service training, the methods of teaching (including handouts, pre and post test if applicable, and the person/position conducting the training).
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SECTION 35.6:  RECORD KEEPING

RECORD KEEPING

A Program of All-Inclusive Care for the Elderly (PACE) organization must abide by all applicable federal and state laws regarding confidentiality and disclosure for mental health records, medical records, and other recipient health information that qualifies as protected health information. The PACE organization must have established written policies and procedures for safeguarding all data, books, and records against loss, destruction, unauthorized use, or inappropriate alteration.

The PACE organization must allow each recipient timely access, upon request, to review and copy their medical records and to request amendments to those records. In addition, the recipient must be given timely notice if the PACE organization intends to charge for copies of records.

A PACE organization must allow Centers for Medicare and Medicaid Services (CMS) and the state administering agency (SAA) access to all administrative, personnel, and recipient records as specified in 42 Code of Federal Regulations (CFR) 460.200(b). This access includes, but is not limited to, data and records, including recipient health outcomes, data, financial books and records, medical and personnel records.

In accordance with 42 CFR 460.200(f) records must be retained for the longest of the following periods:

- The period of time specified by the state law;
- In an accessible location for at least six years from the last entry date;
- For medical records of disenrolled recipients, six years after the date of disenrollment; and
- If a litigation, a claim, a financial management review, or an audit arising from the operation of the PACE program is started before the expiration of the retention period, the PACE organization must retain the records until the completion of the litigation or resolution of the claim or audit findings.

Administrative/Personnel Records

The PACE organization must maintain at a minimum the following information in an administrative file:

- Documents identifying the governing body;
Quality assessment and performance improvement program;

Development of policies consistent with the mission;

Management and provision of all services, including the management of contractors;

Establishment of personnel policies that address adequate notice of termination by employees or contractors with direct patient care responsibilities. These policy and procedures need to be in compliance with local, state and federal guidelines;

Fiscal operations; and

Development of polices on recipient health and safety, including a comprehensive, systemic operational plan to ensure the health and safety of recipients.

Personnel records for each employee or contracted staff must contain at a minimum these components:

Orientation to the PACE program;

Verification of current licensure, registration, and/or certification in the state practicing;

Physician credentialing;

Education for all disciplines;

All staff providing direct recipient care must have evidence of one year experience with a frail or elderly population no matter what the licensing requirement;

Competency evaluation program;

Competency program completed prior to performing recipient care and on an ongoing basis by qualified personnel;

PCA personnel file must contain the results of any written or oral testing;

Criminal background checks; and
Be medically cleared for communicable diseases and have all immunizations up-to-date before engaging in direct recipient contact.

Recipient Records

The PACE organization must maintain a single, comprehensive medical record for each recipient, in accordance with accepted professional standards. The medical record must meet the following requirements:

- Be complete;
- Accurately documented;
- Readily accessible;
- Systemically organized;
- Available to all staff; and
- Maintained and housed at the PACE center where the recipient receives services.

At a minimum, the medical record must include the following information and documentation as specified in 42 CFR 460.210:

- Appropriate identifying information;
- Documentation of all services furnished, including a summary of emergency care and other in-patient or nursing facility services;
- Services furnished by employees at the PACE Center;
- Services furnished by contractors and their reports;
- Interdisciplinary assessments, reassessments, Plans of Care, treatments, and progress notes that include a response to treatment;
- Laboratory, radiological, and all test reports;
- Medication records;
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SECTION 35.6: RECORD KEEPING

- Reports of contact with non-professional, non-paid services provided by family, friends, and community/social network;

- Enrollment Agreement (signed and dated documents);

- Physician orders;

- A signed release permitting disclosure of personal information; and

- Advance directives, discharge summaries, and disenrollment justification, if applicable.

The actual incident report is not a required element of the recipient medical record. A narrative description of the care rendered during and subsequent to the incident must be documented in the progress notes of the interdisciplinary team (IDT) members rendering care.
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SECTION 35.7: REIMBURSEMENT

REIMBURSEMENT

General Provisions for Reimbursement

Program of All-Inclusive Care for the Elderly (PACE) services are financed primarily through Medicare and Medicaid capitated payments. PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. PACE organization must provide all needed services for PACE recipients with the capitated funds. PACE providers assume full financial risk for recipients’ care without limits on amount, duration, or scope of services. The PACE organization shall be responsible for payment of the cost of the care in any setting.

The PACE capitation rate is set as a percentage of the upper payment limit (UPL) for what the State would have expected to pay under fee-for-services for enrollees. The rate shall not exceed 95% of the UPL. The UPL was established by utilizing all Medicaid payments for recipients in the Nursing Home, Home and Community Based Services (HCBS) waiver, the Community Choices Waiver (CCW), Adult Day Health Care (ADHC) waivers and the Long Term Personal Care Services (LTP-CS), who met the PACE enrollment criteria, including meeting nursing facility level of care requirement.

Claims data was collected for all such Individuals as was eligibility data and three rate groups were established:

[1] Those with Medicare Part A or Medicare Parts A & B;
[2] Those with Medicare Part B only; and

For each rate group, the average cost per service month was initially calculated from January, 2003 to October, 2006, based on Date of Service. In order to accommodate lag time between Date of Service and Date of Payment, data was extracted in December 2006 from claims paid as of the end of October 2006. A 12 month average was calculated and multiplied by 12 to estimate annual average cost per enrollee. The amounts were multiplied by 95% to assure a 5% saving.

Under Medicaid regulation, when an individual enters a nursing facility as a permanent Medicaid nursing home resident, a determination of the individual’s required contribution towards the cost of care is based on their monthly income and allowable expenses, otherwise known as a “patient liability” (PLI) amount.

The PLI amount is a shared cost between the resident and Medicaid related to nursing facility placement. Patient liability amounts can vary greatly.

The PLI amount is paid to the PACE provider or contracted nursing facility. The PLI paid by the recipient will serve to discount the contracted rate paid by PACE to the nursing facility.
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SECTION 35.7: REIMBURSEMENT

Department of Health and Hospitals (DHH) has the right to audit the PACE provider’s PLI documentation.

If PLI is not paid by the recipient, the recipient may be involuntarily disenrolled from the PACE program. In accordance with 42 Code of Federal Regulations (CFR) 460.164(a) (1) and state regulation, and through a federally approved PACE specific waiver under the authority of Section 903 of the Benefits and Protection Act, a recipient may be involuntarily disenrolled if they fail to pay, or to make satisfactory arrangements to pay, any PLI due to PACE organization after a 30 day grace period.

The PACE organization must make every opportunity available for recipients to pay PLI and ensure that recipients are not involuntarily disenrolled without good cause. The PACE organization must establish strict guidelines for the involuntary disenrollment process and follow all rules for involuntary disenrollment.

Involuntary disenrollment will occur only after all attempts at resolving the issues have been exhausted. The state will continue to review each request for involuntary disenrollment on a case-by-case basis for approval or disapproval. The PACE organization shall document reasons for the disenrollment and all efforts to resolve the problem.

The PACE organization must provide recipients with reasonable advance notice of disenrollment. During the interim period between notifying the recipient of an upcoming disenrollment and the effective date of the disenrollment, the PACE organization must continue to furnish all needed services.

Policies Specific to Program Rules Federal and State

In accordance with federal and state regulation the PACE organization or their contracted nursing facility must collect PLI for recipients placed permanently/long term in a nursing facility.

Federal regulation 42 CFR 460.186 allows the PACE organization to accept private-pay recipients and to collect a premium from individuals who are Medicare-only or Medicaid-only beneficiaries. Medicare eligible recipients who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. Recipients may be private pay if they choose the service, but do not meet the requirements for Medicaid eligibility. The PACE enrollees not qualifying for Medicaid (private pay or those covered under long term care insurance) would pay an amount equivalent to the lowest applicable Medicaid capitated payment.
CLAIMS FILING

Program of All-Inclusive Care for the Elderly (PACE) organizations do not file claims; they receive a capitated payment at the beginning of each month from Medicare and/or Medicaid or private pay funds, based on the recipient’s eligibility. The fiscal intermediary (FI) pulls out eligibles from MEDS (recipient) file and pays a capitated rate based on eligibility.
PROGRAM MONITORING/QUALITY

Under a Program of All-Inclusive Care for the Elderly (PACE) program agreement, the PACE provider, Centers for Medicare and Medicaid Services (CMS), and the state administering agency (SAA) shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals. As specified in 42 Code of Federal Regulations (CFR) 460.202, a PACE organization must establish and maintain a health information system that collects, analyzes, integrates, and reports data necessary to measure the organizations performance, including outcomes of care furnished to recipients. The data elements for monitoring are regularly reported by PACE organizations via the Health Plan Management System (HPMS). These items are specified in the PACE program agreement.

CMS requires the following nine data elements to be submitted quarterly by the PACE organization through the HPMS system:

- Routine immunizations;
- Grievances and appeals;
- Enrollments;
- Disenrollments;
- Prospective enrollees;
- Re-admissions to acute care hospitals;
- Emergent (unscheduled) care (emergency department in hospital or outpatient clinic);
- Unusual incidents for recipients and the PACE site, including staff if a recipient was involved (e.g., falls, van accidents, attempted suicide, medication errors, recipient injuries, etc.); and
- Deaths.

Level One Reporting Requirements refer to those data elements for monitoring that are regularly reported by the PACE organization via HPMS. The HPMS database is regularly monitored by CMS and SAA. PACE organization shall use the data to identify opportunities for quality improvement.
Level Two Reporting Requirements apply specifically to unusual incidents that result in serious adverse health outcomes for recipient, or negative national or regional notoriety related to the PACE program. When unusual incidents meet specified thresholds PACE organizations must report them within on a timely basis to CMS and SAA. Level Two incidents require internal investigation and analysis of the occurrences by the PACE organization with the goal of identifying system failures and improvement opportunities. PACE organization must determine if the Level Two report requires a root cause analysis.

The National PACE Association (NPA) uses a web based benchmarking data collection system, DataPACE 2, which is maintained and managed by NPA. The DataPACE 2 data is used to create the PACE profile. DataPACE 2 provides NPA members the ability to cross-site data analysis and benchmark the data, prepare reports on recipient characteristics and monitor the development of the PACE model of care. Data collected includes, but is not limited to, areas of quality of care; recipients served, and service utilization. This data is compiled quarterly. Louisiana PACE organizations must participate in DataPACE 2. Data must be submitted by the PACE organization according to the most current NPA Data Calendar schedule. The data must be submitted timely so that validation is accurate. The due date for complete data submittal is 30-90 days after the end of a quarterly reporting period ends. The PACE organization must review the measurement results for the reporting period and validate their accuracy 120 days after each quarter. The State administering agency (SAA) monitors and reviews the compilation of data collected.

As required by 42 CFR 460.130, the PACE organization must develop, implement, maintain, and evaluate an effective data-driven quality assessment and performance improvement (QAPI) program. The QAPI program must include the full range of services provided by the PACE organization. The PACE organization must have the QAPI plan annually reviewed by the PACE governing body and revised if necessary in accordance with 42 CFR 460.132.

The PACE organization’s QAPI plan must include, but not limited to:

- Identify areas to improve or maintain the delivery of services and patient care;
- Develop and implement plans of action to improve or maintain quality of care; and
- Document and disseminate the results of the QAPI activities to the PACE employees and contractors.

**Interviews**

As required by 42 CFR 460.136(c), a PACE organization must ensure that all interdisciplinary team (IDT) members, PACE staff, and contract providers are involved in development and
implementation of QAPI activities. The quality improvement coordinator must encourage PACE recipients and his/her caregivers to be involved in QAPI activities, including providing information about their satisfaction with services.

As defined by 42 CFR 460.138, a PACE organization must establish one or more committees with community input to evaluate data collected pertaining to quality measures, address the implementation of, and results from, the QAPI plan and provide input related to ethical decision making.

**Results**

As defined by 42 CFR 460.134, the PACE organization QAPI program must, at a minimum, include the use of objective measures to demonstrate improved performance to the following:

- Utilization of PACE services such as decreased inpatient hospitalizations and emergency room visits;
- Measure and evaluate caregiver and recipient satisfaction with care and services;
- Outcome measures that are data collected during assessments;
- Effectiveness and safety of staff provided and contracted services; and
- Nonclinical areas as recipient and caregiver complaints and grievances.

The information on voluntary disenrollments must be used in the PACE organizations internal QAPI program as specified by 42 CFR 460.164 (c).

**Plan of Correction**

As required by 42 CFR 460.136(a), a PACE organization must use a set of outcome measures to identify areas of good or problematic performance; take actions targeted at maintaining or improving care based on outcome measures; incorporate actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time; set priorities for performance improvement, considering prevalence and severity of identified problems, and give priority to improvement activities that affect clinical outcomes; and immediately correct any identified problem that directly or potentially threatens the health and safety of a PACE recipient.
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SECTION 35.10: COMPLAINT PROCEDURES

COMPLAINT PROCEDURES

In an exception to the State of Louisiana licensing requirement for Adult Day Health Care (ADHC), a Program of All-Inclusive Care for the Elderly (PACE) organization shall utilize the federal PACE complaints/grievances processes.

As required by 42 Code of Federal Regulations (CFR) 460.120 the PACE organization must have established process to resolve written or oral complaints/grievances expressing dissatisfaction with service delivery or the quality of care provided from PACE recipients, family members, and their representatives. There must be a formal written process to evaluate and resolve medical and nonmedical grievances by recipients, family members, or representatives. Upon enrollment and at least annually the recipient must be given written information on the grievance process. The PACE organization must continue to furnish all required services to the recipient during the grievance process. The PACE organization must discuss and provide to the recipient in writing specific steps and timeframes for response that will be taken to resolve the recipient’s grievance.

All personnel (employees and contractors) who have contact with recipients should be aware of and understand the basic procedures for receiving and documenting grievances in order to initiate the appropriate process for resolving recipient concerns.

At a minimum the grievance process must include:

- How to file a grievance;

- Documentation of the grievance:
  - Date the grievance was received;
  - Nature of the grievance;
  - Letter of reference to timeframes/resolution;
  - Date of resolution of grievance; and
  - Date of notification of resolution provided to the recipient;

- Response to and resolution of the grievance in a timely manner; and

- Maintenance of the recipient’s confidentiality throughout the process of the grievance and thereafter to prevent unauthorized access.
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SECTION 35.10: COMPLAINT PROCEDURES

Internal Appeals Process

Complaints concerning denial of services or service coverage must be handled as appeals. In accordance with 42 CFR 460.122 the PACE organization must have a formal written internal appeals process, with specified timeframes for response, to address non-coverage of, or nonpayment for, a service including denials, reductions, or termination of services.

The recipient must receive written information on the appeals process at enrollment, at least annually thereafter and whenever the interdisciplinary team (IDT) denies a request for services or payment. The PACE organization’s responses to and resolution of the appeal must be no later than 30 calendar days after the organization receives an appeal.

The PACE organization’s internal appeal process must include but not limited to:

- Timely preparation and processing of a written denial of coverage or payment;

- How a recipient files an appeal;

- Documentation of a recipient’s appeal;

- Appointment of an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the recipient’s appeal;

- Responses to and resolution of, appeals expeditiously as recipient’s health condition requires, but no later than 30 calendar days after the organization receives the appeal; and

- Maintenance of confidentiality of appeals.

An expedited internal appeals process should be available for situations of urgency when the PACE recipient believes not having the service would place his/her life or ability to function in jeopardy. The PACE organization must respond no later than 72 hours after it receives the appeal. The PACE organization may extend the 72 hour timeframe by up to 14 calendar days for either of the following reasons:

- The recipient requests an extension; or

- The PACE organization justifies with the State administering agency (SAA) the need for additional information and how the delay is in the interest of the recipient.
An appeal decision will be given to the recipient in writing. If after the internal appeal process, the PACE recipient is not satisfied with the determination, then an external appeal to Medicaid or Medicare may be requested and the PACE organization must forward the appeal to the appropriate external entity.

**External Appeals Process**

A PACE organization must inform a recipient in writing of his or her appeal rights under Medicare or Medicaid managed care or both, assist the recipient in choosing which to pursue if both are applicable, and forward the appeal to the appropriate external entity.

PACE organization shall submit proposed denial of enrollment determinations of applicants for health and safety reasons and all involuntary disenrollment determinations of recipients to OAAS RO for review prior to notifying applicants/recipients of such adverse decisions.

Medicaid eligible recipients who appeal through Medicaid shall be heard by the Health and Hospitals Section of the Division of Administrative Law (DAL) within the timeframes applicable to processing Medicaid appeals, except in cases where federal PACE requirements require a more expeditious decision.

The OAAS RO must prepare the Summary of Evidence (SOE) for appeals in which OAAS RO has made any adverse action determination that is appealed by the applicant/recipient.

If the initial or reassessment MDS-HC (involuntary disenrollment) determined the applicant/recipient does not meet nursing facility level of care the PACE organization must notify the OAAS RO to request a final determination review of all enrollment data, including the MDS-HC. The OAAS RO will ensure the accuracy of the enrollment data and make the final determination regarding nursing facility level of care. OAAS RO shall be responsible for assuring that all avenues of eligibility have been explored prior to determining that an individual does not meet the required nursing facility level of care or meet deemed eligibility for continuation of services. OAAS RO shall notify the PACE organization of the final determination. When the PACE applicant/recipient does not meet nursing facility level of care the OAAS RO must prepare the Summary of Evidence (SOE) for appeals. OAAS RO must issue a denial letter and appeal rights to the recipient and copy the PACE organization. The PACE organization must provide the applicant with any referral sources that may be indicated.

If involuntary disenrollment is approved the PACE organization will follow their written appeals process. The PACE organization must provide recipients with reasonable advanced notice of disenrollment and applicable referrals and recommendations for alternate healthcare options. The PACE organization must continue to furnish all needed services until the recipient is back in the Medicare/Medicaid (If eligible) fee-for-service systems as specified in 42 CFR 460.166.
The PACE organization must prepare the SOE in preparation for any appeals in which the PACE organization has made any adverse action determination that was appealed by the applicant/recipient.

For a Medicaid recipient the PACE organization must continue to furnish the disputed services until issuance of the final determination by the DAL is issued if the following conditions are met:

- The PACE organization is proposing to terminate or reduce services currently being furnished to the recipient; and
- If a timely appeal is not filed, services will be terminated effective at the end of the month in which the denial notice was issued.

**Reporting**

The PACE organization must maintain, aggregate, and analyze information on grievance proceedings and appeals information. This information must be used in the PACE organization’s internal quality assessment and performance improvement (QAPI). The QAPI program must include mechanisms to receive and address recipient and care giver complaints and grievances and, when necessary, take appropriate corrective action(s).

The PACE organization must report grievances and appeals quarterly through the Health Plan Management System (HPMS) as indicated in the PACE program agreement.
Sanctions, Enforcement Actions, and Termination

Centers for Medicare and Medicaid Services (CMS) and the state administering agency (SAA) have the ability to levy sanctions in the form of civil money penalties, a suspension of payments, and termination of the contract for a variety of offenses as they relate to the operation of the Program of All-Inclusive Care for the Elderly (PACE) program. In an exception to the Standards of Payment, any violation of the Adult Day Health Care (ADHC) regulations as otherwise promulgated that would warrant sanctions may be applied only to the ADHC component of PACE.

CMS and the SAA report the results of the reviews to the PACE organization, along with any recommendations for changes to the organization’s program. The PACE organization must write a corrective action plan (CAP), a description of the action plan that will be taken to correct the identified deficiency.

The PACE organization must take action to correct deficiencies identified during the reviews as required by 42 Code of Federal Regulations (CFR) 460.194. CMS or SAA monitors the effectiveness of the corrective action. Failure to correct deficiencies may result in sanctions or termination. Disclosure of the review results must be available as demonstrated by 42 CFR 460.196.

CMS may impose any of the sanctions specified in 42 CFR 460.42 and 42 CFR 460.46 if the PACE organization commits any of the following violations:

- Fails substantially to provide a recipient medically necessary items and services that are covered PACE services, if the failure adversely affected (or has substantial likelihood of adversely affecting) the recipient;
- Involuntarily disenrolls a recipient in violation of 42 CFR 460.164;
- Discriminates in enrollment or disenrollment among Medicare beneficiaries or Medicaid recipients, or both, who are eligible to enroll in a PACE program, on a basis of an individual’s health status or need for health care services;
- Engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by 42 CFR 460.150, by Medicare beneficiaries or Medicaid recipients whose medical condition or history indicates a need for substantial future medical services;
- Imposes charges on recipients enrolled under Medicare or Medicaid for premiums in
excess of the premiums permitted;

- Misrepresents or falsifies information that is furnished to CMS or the State under this part or to an individual or any other entity under this part;

- Prohibits or otherwise restricts a covered health care professional from advising a recipient who is a patient of the professional about the recipient’s health status, medical care, or treatment for the recipient’s condition or disease, regardless of whether the PACE program provided benefits for that care or treatment, if the professional is acting within his or her lawful scope of practice;

- Operates a physician incentive plan that does not meet the requirements of section 1876(i) (8) of the Act; and

- Employs or contracts with any individual who is excluded from the participation in Medicare and Medicaid under section 1128 or section 1128A of the Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization review, medical social work, or administrative services.
ACRONYMS/DEFINITIONS/TERMS

This is a list of acronyms, definitions and terms used in the Program of All-Inclusive Care for the Elderly (PACE) Manual Chapter.

Activities of Daily Living (ADL) – Those activities that are required by an individual for continued well-being, health and safety. This includes basic personal everyday activities as bathing, dressing, transfer, toileting, mobility, and eating.

Adult Day Health Care (ADHC) – A group program designed to meet the individual needs of functionally-impaired adults which is structured and comprehensive and provides a variety of health, social, and related support services at a licensed day site.

Appeal – The participant’s action taken with respect to the PACE organization’s non-coverage of, nonpayment for a service, including denials, reductions, or termination of services.

Applicant – An individual whose written application for Medicaid or Department of Health and Hospitals (DHH) funded services has been submitted to DHH but whose eligibility has not yet been determined.

Assessment – The process of gathering and integrating formal and informal information relevant to the development of an individualized Plan of Care.

Audit – An external review of the PACE organization’s practices and procedures to determine compliance with CMS program requirements.

Audit Team – A group of people comprised of Centers for Medicare and Medicaid Services (CMS), State administering agency staff (SAA), or other designees who are responsible to perform a PACE organization audit.

Balanced Budget Act of 1997 (BBA) – Established PACE model as a permanently recognized provider type under both the Medicare and Medicaid programs and mandated that the quality of care be monitored.

Bureau of Health Services Financing (BHSF) – The Bureau within DHH responsible for the state administration of the Louisiana Medicaid Program.

Centers for Medicare and Medicaid Services (CMS - formerly HCFA) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.
CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.12 – ACRONYMS/DEFINITIONS/TERMS

Code of Federal Regulations (CFR) – A publication by the Federal government containing PACE requirements which organizations must comply with to receive payment under Medicaid/Medicare programs.

Complaint – see Grievance.

Confidentiality – The process of protecting a participant’s or an employee’s personal information, as required by the Health Insurance Portability and Accountability Act (HIPAA).

Contract year – Means the term of a PACE program agreement, which is a calendar year, except that a PACE organization’s initial contract year may be from 12 to 23 months, depending on the effective date of program implementation (as determined by CMS).

Corrective Action Plan (CAP) – Written description of action a provider agency plans to take to correct identified deficiencies.

Corrective Action Requirement (CAR) – A term historically used in audit report requesting a CAP from the PACE organization in response to a deficiency.

Deemed Status – PACE participants who do not meet nursing facility level of care on annual reassessment, and who in the absence of continued coverage would be expected to meet the nursing facility level of care requirements within the next 6 months.

Department of Health and Hospitals (DHH) – The state agency responsible for administering the state’s Title XIX (Medicaid) Program and other health and related services including aging and adult services, public health, mental health, developmental disabilities, and addictive disorder services.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Division of Administrative Law (DAL) – The state agency responsible for the due process system ensuring the participant has an opportunity to contest certain decisions.

Enrollment – A determination made by DHH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other DHH-funded services. This is also referred to as provider enrollment or certification.

Fiscal Intermediary (FI) – The private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.
**Grievance** – a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality or care furnished.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)** – Legislation passed in 1996 that addresses security and privacy of health data and requires CMS to establish national standards of electronic health care transactions and national identifiers for providers, health plans, and employer.

**Health Plan Management System (HPMS)** – A CMS internal health information system that collects, analyzes, integrates, and reports data to measure the PACE organization’s performance and to develop and implement procedures to furnish data pertaining to the provision of care to external oversight entities in the manner and at the time intervals specified by CMS and SAA. The system monitors the operation; costs, quality, and effectiveness of the PACE program and establish payment rates.

**Health Standards Section (HSS)** – The office within the Department of Health and Hospitals responsible for the licensing and certification of providers.

**Interdisciplinary Team (IDT)** – A group of professionals and paraprofessionals PACE center staff, employed or contracted, involved in assessing the needs of the participant and making recommendations in a team staffing for services or interventions targeted at those needs.

**Level One Event** – Refers to those data elements for monitoring that are regularly reported by PACE organizations via HPMS.

**Level Two Event** – Unusual incidents that result in serious adverse participant outcomes, or negative national or regional notoriety related to the PACE program.

**Licensure** – A determination by the HSS that a service provider agency meets the requirements of state law to provide services.

**Medicaid** – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

**Medicaid Management Information System (MMIS)** – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

**Medicare** – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.
CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.12 – ACRONYMS/DEFINITIONS/TERMS

National PACE Association (NPA) – Non-profit membership organization that represents the interests of PACE organizations. These member organizations share the goal of promoting the availability of quality, comprehensive, and cost-effective health care services to frail older adults through the PACE and similar models of care.

Nursing Facility (NF) – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides long term care and placement for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within the DHH that is responsible for the management and oversight of certain Medicaid home and community-based state plan and waiver programs and protective services for adults ages 18 through 59.

OAAS Regional Office (RO) – One of nine administrative offices within the Office of Aging and Adult Services.

PACE Center – The facility which includes an adult day care, a primary clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining and which serves as the focal point for coordination and provision of most PACE services.

PACE Organization – The entity that has in effect a PACE program agreement to operate a PACE under this part.

PACE Program – An optional service under the Medicaid State Plan that is a capitated, managed care program.

PACE Recipient/Participant – An individual who is enrolled in the PACE program.

Patient Liability (PLI) – The amount a recipient is responsible for paying to a provider of PACE services.

Plan of Care (POC) – The written documentation that outlines how PACE services are delivered to the recipient. A written plan developed by the interdisciplinary team that is based on assessment results and specifies services to be accessed and coordinated on the participant’s behalf. It includes long-range goals, assignment of responsibility, and time frames for completion or review by the interdisciplinary team.

Primary Care Physician (PCP) – A physician, currently licensed by the Louisiana State Board of Medical Examiners who is responsible for the direction of the participant’s overall medical care.

Program of All Inclusive Care for the Elderly (PACE) – a comprehensive and supportive services program designed to assist those 55 or older to remain at home and in the community.
CHAPTER 35: PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

SECTION 35.12 – ACRONYMS/DEFINITIONS/TERMS

Quality Assessment and Performance Improvement (QAPI) – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to PACE participants, to pursue opportunities to improve services, and to correct identified problems.

Recipient – An individual who has been certified for medical benefits by the Medicaid Program. A recipient certified for Medicaid services may also be referred to as a participant.

Sanction – Denial of benefits for failure to comply with an eligibility requirement.

Service Area – The geographically designated (by zip code/parish areas) region where PACE services are provided.

Services – This includes both items and services.

State Administering Agency (SAA) – The state agency responsible for administering the PACE program.

State Readiness Review (SRR) – The purpose of this review is to determine the organization’s readiness to administer the PACE program and enroll and serve participants. Every application must meet all requirements of the SRR prior to enrolling participants.

Transition – The steps or activities conducted to support the passage of the participant from existing formal or informal services to the appropriate level of services, including disengagement from all services.

Trial Period – Means a PACE Program that is operated by a PACE provider under a PACE program agreement, the first 3 years under such an agreement.